STATE OF WASHINGTON DEPARTMENT OF LABOR AND INDUSTRIES

PO Box 44261 Olympia, Washington 98504-4261

BILLING INSTRUCTIONS – STATE FUND CLAIMS HCFA – 1500 BILL FORM

F245-127-000

Ambulatory Surgery Center,
Anesthesiologist, Chiropractor, CRNA, Hospital ER/Professional
Services, Laboratories, Naturopath, Osteopathic Physician,
Outpatient Pain Management Program, Panel Examiner, Pathologist, Physical Therapist,
Physician, Physician Assistant, Physician Clinic,
Podiatric Physician, Psychologist, Radiologist

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BILLING INSTRUCTIONS

Labor and Industries (L&I) processes all provider bills using an automated system called the Medical Information Payment System (MIPS). In order to process your bills promptly and accurately, they must be completed as described in these instructions. Improperly submitted bills will be denied or returned for completion or correction.

For billing requirements for Self-Insurers and their service companies contact the Self-Insurance section at 360-902-6901.

L&I Provider Account Number Required:

If you do not have an L&I provider account number, please call Provider Accounts at (360) 902-5140 to request a provider application form. This form and several other of the most frequently requested forms can also be downloaded from our website at www.wa.gov/lni/forms. You may also request additional forms from your local field service location; a listing of these locations is contained on the last page of this billing instruction booklet. Submit your bill after you receive your L&I provider account number or for your first submission only, attach it to your completed application.

Billing on Paper Forms:

Submit charges on the "HCFA-1500" bill form (F245-127-000).

Mail HCFA-1500 bill forms to:

Department of Labor and Industries PO Box 44269 Olympia, Washington 98504-4269

Bill Forms - Where and How to get them:

Bills must be submitted on ORIGINAL (not photocopied) HCFA-1500 bill forms. Bill forms are furnished free of charge to providers. To order forms, contact the Labor and Industries Field Service Location office nearest you; a listing of these locations is contained on the last page of this billing instruction booklet. Providers outside Washington State may contact Provider Accounts at

(360) 902-5140 or the Provider Hotline at 1-800-848-0811. When ordering, give your full name, address, L&I provider account number, quantity needed for six months, and the L&I form number (FXXX-XXX-000 for single sheet, or FXXX-XXX-111 for continuous pinfeed).

Billing Electronically:

Please contact the Electronic Billing Unit at (360) 902-6511 or (360) 902-6512 if you are able to and are interested in submitting bills electronically.

When to Submit Bills:

You should submit bills at the time the first required report is written. Billings should then be sent every 30 days thereafter until the conclusion of services. A separate bill form must be completed for each claim number but each bill form may contain more than one date of service. All dates of service must be billed separately.

When payments are made:

The department issues warrants to providers every two-weeks for bills that have processed to final status. An L&I Remittance Advice is also provided to you at two-week intervals. Remittance Advices provide a report of the status of your bill(s) that have been processed, or are in process. When contacting the department with a billing problem, please have the appropriate copy of the Remittance Advice in hand before calling. Many

billing questions can be answered by reading the Remittance Advice.

Credit Balance Bills (CRE) – The bills will be held in abeyance until the credit balance is satisfied. These bills should be treated as "Bills in Process". Do not post or rebill these bills as long as they appear in this section. **This is money owed to the department.** Payment(s) to clear your credit balance should be mailed to:

Department of Labor and Industries Cashier's Office PO Box 44835 Olympia WA 98504-4835

Limits on Bill Processing:

Bills must be received within one year of the date of service to be considered for payment. Rebills must be submitted for services denied if a claim was closed and subsequently reopened or if a claim or diagnosis was rejected and subsequently allowed. In these instances, the rebill must be received within one year of the date the final order is issued, which subsequently reopens or allows the claim or diagnosis.

For Help:

If you have questions about "PAID BILLS", "DENIED BILLS" or "ADJUSTMENT BILLS", please call the Provider Hotline at 1-800-848-0811. **Please have a copy of the appropriate Remittance Advice in hand before calling.**

If you have questions about "BILLS IN PROCESS", please call the automated Claim Information line at 1-800-831-5227, for up to the minute bill status. From that line, you may choose the "zero" option to be connected to the Bill Payment Unit.

If you have general questions about an injured workers claim or time-loss payment, please call the automated Claims Information line at 1-800-831-5227. More than one claim number can be accessed per phone call and any 'wait time' is minimal.

If an injured worker has general questions about their claim, please give them the 1-800-831-5227 number or the 1-800-LISTENS (547-8367) number for assistance with claim problems including time-loss. If they have bill questions, you may give them the Provider Hotline number 1-800-848-0811.

Note: A completed Report of Accident does not constitute a bill. Bills must be submitted separately to be considered for payment.

REPORTING REQUIREMENTS

DO NOT ATTACH REPORTS TO THE BILLS

The following required **reports** and **documentation** must be sent separately from your bills in order for them to be routed to the proper department and placed in the proper file:

- a. Consultation reports
- b. Laboratory and X-ray reports
- c. Special reports and/or narratives to support level of office visit or procedure
- d. Operative reports/anesthesia records
- e. Periodic office notes
- f. Periodic chart notes

The injured workers' name and claim number must be placed in the upper right corner of <u>each page</u> on any correspondence or report.

The cost invoices for supplies furnished are not routinely required to be mailed to the department, but may be requested in specific cases.

See WAC 296-20 for additional requirements and report definitions.

Send all reports and documentation for State Fund claims to:

Department of Labor and Industries PO Box 44291 Olympia WA 98504-4291

PROVIDER SPECIFIC INSTRUCTIONS

Ambulatory Surgery Center

Type of service:

Use type of service code "3" with CPT® and HCPCS codes.

Modifiers:

May use SG modifier with each line item.

CPT® modifers: 50, 51, 52, 59, 73, 74, 76, 77, 99

Ambulatory Surgery Centers (ASCs) must have a valid ASC provider account with L&I to be paid for services.

ASCs will not be paid for services, which are not covered by the department. Non-covered codes are listed in the ASC section of the *Medical Aid Rules and Fee Schedules*.

ASCs should bill for implants on a separate line. The following HCPCS implant codes are covered by the department in an ASC: L8500 through L8699. Intraocular lenses (i.e. V2630, V2631, V2632) are the exception. These are included in the facility payment and will not be paid separately. ASCs will be paid the acquisition cost for all implants.

For injection procedures which require the use of radiographic localization and guidance, ASCs must bill for the technical component of the radiological CPT® code (e.g. 76005 – TC).

For more information, please refer to WAC 296-23B, Provider Bulletin 01-12, and to the ASC sections of the *Medical Aid Rules and Fee Schedules*. Information can be viewed and downloaded from www.lni.wa.gov/hsa.

Anesthesiologist

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

Modifiers

CPT Modifiers: -23 & -99

HCPCS Modifier: -AA, -QK and -QY

Anesthesiologists must have valid individual L&I provider account numbers to be paid for services. The department does not cover anesthesia assistant services.

Anesthesia is not payable for procedures that are not covered by the department. Non-covered codes are listed in Appendix E of the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Anesthesia services paid with base and time units must be billed using CPT anesthesia codes 00100 through 01999 or ASA codes 01951 and 01952. Refer to "Anesthesia Services Paid with Base and Time Units" in the

Anesthesia Payment Policies section in the current Medical Aid Rules and Fee Schedules.

Effective for dates of service on or after July 1, 2000, anesthesia reimbursement will be calculated using 15-minute time units. This change does not affect how providers bill for services, or how the department calculates payments. Providers should continue to bill for services in one-minute time units.

For more information, please refer to the "Anesthesia Payment Calculation" section of the current Medical Aid Rules and Fee Schedules, and to the current PB 00-05. Provider Bulletins can be viewed/downloaded from www.wa.gov/lni/hsa/hsa_pbs.htm.

Chiropractor

Type of Service:

Use Type of Service code "C" with CPT, HCPCS and Local Codes

The department will not pay chiropractic physicians for additional codes that are not specifically allowed. Refer to the appendices in the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Chiropractic Care Visit Payment Policies

- Only **one** chiropractic care visit code is payable per day.
- Chiropractic care visit codes are payable in addition to E/M office visit codes **only when all of the following conditions are met:**
 - The E/M service is for the **initial visit** for a **new claim**, and
 - The E/M service constitutes a significant separately identifiable service that exceeds the usual pre and post service work included in the chiropractic care visits, and
 - Modifier -25 is added to the new patient E/M code, and
 - Supporting documentation describing the service(s) provided is included in the patient's record.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 will be individually reviewed when billed with chiropractic care visit local codes (2050A to 2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- When a reopening application is filed, the services required to complete the application will be paid regardless of the insurer's action on the application:
 - When performed on the same day as completion of the reopening application (local code 1041M), an E/M visit (with -25 modifier when a chiropractic treatment code is also billed) and covered diagnostic studies (including x-rays) will be paid.
 - Treatment procedures on the same date and subsequent to the application date will only be paid if the claim is reopened, as no treatment is payable on denied reopenings (closed claims).

For more information, please refer to WAC 296-23-195 and the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

CRNA

Type of Service:

Use Type of Service code "N" with CPT, HCPCS and Local Codes.

CRNA services will be paid at a maximum of ninety percent of the allowed fee that would otherwise be paid to a physician. The only modifiers that are valid for CRNAs are –QX and –QZ (see the "Anesthesia Modifiers" section in the current Medical Aid Rules and Fee Schedules.

CRNA services must be billed on a separate HCFA-1500 form from those of an anesthesiologist, since they each have their own modifiers and provider account numbers. This applies to CRNAs providing solo services as well as team care.

For more information, please refer to WACs 296-23-240 and -245.

Hospital ER/Professional Services

Type of Service:

Use Type of Service code "3" with CPT and HCPCS codes

Hospitals must submit charges for ambulance services and professional services provided by hospital staff physicians on the HCFA-1500 bill form using the provider account number(s) assigned by the department specifically for ambulance services and professional services.

For more information, please refer to Chapter 296-23A "Hospitals" section in the current Medical Aid Rules and Fee Schedules.

Laboratories

Type of Service:

Use Type of Service code "3" with CPT Codes

For more information, please refer to the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

Naturopath

Type of Service:

Use Type of Service code "D" with HCPCS Codes and Local Codes

For more information, please refer to the "Specialty and Administrative Services" section and WAC 296-23 in the current Medical Aid Rules and Fee Schedule.

Osteopathic Physician

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT) using CPT codes. E/M office visit services are not to be routinely billed in conjunction with OMT. E/M office visit services may be billed in conjunction with OMT *only when all the following conditions are met:*

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post- service work included with OMT.
- There is documentation in a patient's record which supports the level of E/M billed.
- The E/M service is billed using the -25 modifier. E/M codes billed on the same day as OMT codes without the -25 modifier will not be paid.
- The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Outpatient Pain Management

Type of Service:

Use Type of Service code "3" with Local Codes 2000M – 2002M

Provider must have a signed contract with the department to provide these services.

The Contractor will bill its usual and customary (U&C) fee, whether it exceeds or is below the approved maximum fees per WAC 296-20-010.

The Contractor must document in the pain clinic program records the type, frequency, length and itemized billed charges for each service provided. The Department will have access to such records upon request.

The Contractor must indicate the period covered in the bill in the box labeled 24A on the HCFA-1500 form.

Panel Examiner

Type of Service:

Use Type of Service "3" with CPT and Local codes

Doctors who wish to perform Independent Medical Examinations for the department or self-insurers providing coverage to workers covered under Title 51 RCW must be approved examiners. Doctors must submit a completed department application to the Provider Review and Education Unit at the Department of Labor and Industries, PO Box 44322, Olympia, WA 98504 and receive the medical director's approval. Approved examiners will be included on the department's approved examiners list.

For more information, please refer to Chapter 296-23 in the current Medical Aid Rules and Fee Schedules.

Pathologist

Type of Service:

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Use Type of Service code "3" with CPT
Use Type of Service code "9" with HCPCS and Local Codes
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For more information, please refer to the "Specialty and Administrative Services" section in the current Medical Aid Rules and Fee Schedules.

Physical Therapist

Type of Service:

Use Type of Service code "P" with CPT and HCPCS Codes

After 12 treatments, you must get authorization from the attending physician and the claims manager.

For more information, please refer to WAC 296-23-220 and the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Physician and Physician Clinics

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Physician Assistants

Type of Service:

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Use Type of Service code "3" with CPT Codes
Use Type of Service code "9" with HCPCS and Local Codes
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Physician assistants must be certified to qualify for payment. Physician assistants must have valid individual L&I provider account numbers to be paid for services.

Consultation, impairment ratings and administrative or reporting services related to worker's compensation benefit determinations are not payable to physician assistants. Physician assistant services are paid to the supervising physician or employer at a maximum of ninety percent (90%) of the allowed fee.

Further information about physician assistant services and payment can be found in the Provider Bulletin 99-04 and WAC 296-20-01501.

Podiatric Physician

Type of Service:

Use Type of Service code "3" with CPT Codes Use Type of Service code "9" with HCPCS and Local Codes

For more information, please refer to the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

Psychologist

Type of Service:

Use Type of Service code "3" with CPT Codes

A psychiatrist can only be the attending physician on a claim when a psychiatric condition is the **only condition** being treated, and it has been accepted by the department. Psychologists can not be the attending physician and may not certify time loss or rate Permanent Partial Disability under our rules (WAC 296-20-210).

Psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors are **not covered**, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Psychological testing may be administered by staff supervised by a psychiatrist or licensed clinical psychologist. However, the interpretation of testing and preparation of reports must be performed by the psychiatrist or licensed clinical psychologist.

Please refer to WAC 296-21-270, WAC 296-21-280 and "Washington RBRVS Payment Policies" section of the current Medical Aid Rules and Fee Schedules for more information.

Radiologist

Type of Service:

Use Type of Service code "3" with CPT, HCPCS and Local Codes

RT and LT Modifiers

HCPCS modifiers -RT (right side) and -LT (left side) *do not affect payment*, but may be used with CPT radiology codes (CPT codes 70010 – 79999) to identify duplicate procedures performed on opposite sides of the body.

Consultation Services

CPT code 76140, x-ray consultation, is not covered. For radiology codes where a consultation service is performed, providers should bill the specific x-ray code along with the local modifier -1R.

For more information, please refer to Chapter 296-23-135, -140, -145 and the "Washington RBRVS Payment Policies" section in the current Medical Aid Rules and Fee Schedules.

COMPLETING THE "HCFA-1500" FORM

Completed bill forms <u>must</u> be typed or printed and be clearly legible. All of the following boxes <u>must</u> be completed to ensure correct bill adjudication. Use the instructions below to complete the HCFA-1500 Health Insurance Claim Form.

The HCFA-1500 is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing Labor and Industries. (The numbered boxes on the claim form are referred to as fields.) Only those fields, which pertain to billing Labor and Industries, are addressed below.

DO NOT WRITE, PRINT, OR STAPLE ANY ATTACHMENTS IN THE BAR CODE AREA AT THE TOP OF THE FORM.

FIELD DESCRIPTION / INSTRUCTIONS FOR COMPLETION

- la. **INSURED'S I.D. NO.:** Enter worker's social security number. This information will assist us in identifying the injured worker's claim number if the claim number is missing or invalid.
- 2. **PATIENT'S NAME:** Enter injured worker's last name, first name, and middle initial.
- 3. **PATIENT'S BIRTH DATE:** List the birth date of the worker.
- 5. **PATIENT'S ADDRESS:** Enter worker's current address.
- 11. **INSURED'S POLICY GROUP OR FECA (Federal Employees Compensation Act) NUMBER:** Enter worker's L&I claim number. Omission of this number will result in denial of payment.

Claim numbers are alpha-numeric, consisting of seven characters. The letter identifies the funding source which is listed below.

STATE FUND INDUSTRIAL INSURANCE Claim numbers are six digits, preceded by the letter "B, C, F, G, H, J, K, L, M, N, P, X or Y."

Send bills for State Fund claims to:

Department of Labor and Industries PO Box 44269 Olympia WA 98504-4269

CRIME VICTIMS

Crime Victim Compensation Program claim numbers are either six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH or VJ".

Send bills for Crime Victims claims to:

Department of Labor and Industries Crime Victims Compensation Program PO Box 44520 Olympia WA 98504-4520 SELF-**INSURANCE** Self-Insurance claim numbers are six digits preceded by an "S, T or W".

Bills for all Self-Insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

- 14. **DATE OF INJURY/ILLNESS:** The date of injury/illness positively identifies each claim. This is important and must be included. A worker may have several claims; therefore, it is vital the proper claim is identified and charged for services provided.
- 17. NAME OF REFERRING PHYSICIAN: Enter the name of the doctor referring the worker to you, if applicable.
- 17a. I.D. NUMBER OF REFERRING PHYSICIAN OR OTHER SOURCE: This information is required if you have not listed ICD9-CM diagnosis codes in box 21 or 24E.
- 21. **DIAGNOSIS OR NATURE OF INJURY OR ILLNESS:** You may use this space to describe in more detail ICD-9 description or multiple diagnosis. You must fill in specific diagnosis on line 24E for each line item. Designate left or right side of body, when applicable.
- 24. ENTER ONLY 1 (ONE) SERVICE PER LINE
- **DATE OF SERVICE:** Enter numerically the month, day, and year of service (e.g., January 04, 2000) 24a. = 010400). When billing for more than one date of service, only consecutive days may be billed on the same line. If dates of service are not consecutive, list each date on a separate line.

Example: Office visits made on January 3, 4, and 5 may be billed as one entry: 010300 - 010500. A "3" is entered in the units column (24g). However, office calls made on January 2, 4, and 8 should be listed on separate lines. A "1" should be entered in the units column for each date.

- 24b. PLACE OF SERVICE: Do not use the Place of Service codes listed on the back of the HCFA-1500 forms not obtained from our department. Enter required 2-digit place of service code. See list of codes in the Place of Service section of this booklet.
- 24c. **TYPE OF SERVICE:** Enter the appropriate Type of Service code. The necessary number or character is contained below. Different types of service require different Type of Service codes. Refer to provider specific instructions

Type of Service	For which Provider
C	Chiropractors
3	Medical Services: Physicians/Physician
	Assistants, Psychologist, Osteopathic Physicians, Laboratories,
	Pathology, Radiology, Outpatient Pain Management
	Programs, Anesthesiologists
${f N}$	Advanced Registered Nurse Practitioners,

24d. **PROCEDURE, SERVICE, OR SUPPLY:** Identify the procedure (CPT/HCPCS/Local Code) performed. Enter only one code per line.

Please Note: The department does not publish sufficient descriptive CPT and HCPCS information to properly code provided services, since it is already available in these books. Providers and self-insurers must refer to their own copies of these books to determine the appropriate code(s) to use for billing and payment.

ATTN: All Providers – If service is listed as bundled in the fee schedule, <u>DO NOT</u> include it on the bill form. Codes that are determined as bundled by the department, will be automatically denied.

CODE MODIFIER: A modifier indicates a performed service or procedure has been altered by a specific circumstance. A complete list of procedure code modifiers can be found in the RBRVS & Anesthesia Section of the Fee Schedule. Indicate modifier, if applicable, after the procedure code. Example: 20816-80.

DESCRIPTION OF SERVICES: Describe services provided, e.g., apply long leg cast. When service is coded "unlisted" in CPT-IV, the treatment or diagnostic study must be fully described.

- 24e. **ICD-9-CM DIAGNOSIS CODE NUMBER:** One code must be recorded in this box for each line item if you do not provide referring physician ID number (in box 17a).
- 24f. **CHARGES:** Enter your usual and customary fee for the procedure billed on this line. (Do NOT bill negative charges)
- 24g. **DAYS OR UNITS:** Enter the total number of units, minutes, or days for the services billed on a line.
- 25. **FEDERAL TAX I.D. NUMBER:** Required. If the L&I provider account number is missing or invalid, this information helps to identify the correct provider for payment.
- 26. **PATIENT'S ACCOUNT NO.:** The number you use to identify your patient's account. This is for your convenience only.
- 28. **TOTAL CHARGES:** Total of all charges.
- 31. **SIGNATURE:** Signature may be that of the provider or the person preparing the bill. Regardless of who signs the bill, the provider submitting the bill is responsible for its accuracy. For computer generated bills, the signature may be left blank. The "DATE" is the date the bill is prepared and sent to the department or self-insurer.
- 32. **NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED:** Physical location where services were rendered.
- 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE, AND PHONE #: Enter the name of the provider providing the services (enter last name first) and current address. If there are any changes in the provider's address or status, immediately notify Provider Accounts in writing or via fax at the following address/fax number:

Provider Accounts Department of Labor and Industries PO Box 44261 Olympia WA 98504-4261 Fax 360-902-4484

PLEASE INCLUDE THE L&I PROVIDER ACCOUNT NUMBER(S) YOU'RE SUBMITTING A CHANGE FOR ON YOUR CORRESPONDENCE.

Indicating a new address on the bill will not change the department's record of your address and could delay payment.

PIN #: Enter the L&I provider account number assigned by L&I for the performing provider of service. Failure to enter your performing providers L&I provider account number will result in the bill being returned and/or denied.

GROUP #: If payment is to be made to a group/clinic or supervising physician (Payee) rather than the provider performing the service, you must enter the group/clinic or supervising physician's (Payee) account number designated by L&I. Include the first two characters of the group/clinic name or the first two characters of the supervising physician's last name. The name must correspond with the account number used.

This applies only to the provider groups where the group/clinic has been assigned a

29. **main L&I provider account number (Payee)** and the members of the group have been assigned individual L&I provider account numbers.



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

PLEASE PRINT OR TYPE

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21. DIAGNOSIS OR NATU	RE OF ILLNESS (or injury.	•		R 4 TO ITE	M 24E B	Y LI	NE)		22. MEDICAID RE CODE	ESUBMIS	SION	ORIG	INAL REF	. NO.
1.			3.	·				·	F	23. PRIOR AUTH	ORIZATIO	I ON NUMB	BER		
2.			4.	·											
24. A	В	С		D				E		F	G	Н	I	J	К
DATE(S) OF SERVIC	SERVICE	Type Of Service	(Exp	OURES, SERVI	Circumstand	ces)	6	DIAGNOSIS	S		Days Or Units	EPSDT Family Plan	EMG	СОВ	RESERVED FOR
MM DD YY MM DD	YY		CPT	/HCPCS	MODII	FIER		CODE		\$ CHARGES					LOCAL USE
	1			ı	ı					1					
				'						1					
		1								L					
	ı			ı	1					ı					
25. FEDERAL TAX I.D. NU	MBER SSI	N EIN 2	6. PATIENT'	S ACCOUNT N	10.	27. AC	CEPT	ASSIGNMENT?	T	28. TOTAL CHAR	GE 2	9. AMOU	INT PAII)	30. BALANCE DUE
							۱ ۱	res LI NO		\$	\$	5		ı	\$
31. PHYSICIAN/SUPPLIER SIG DEGREES OR CREDENTIALS	(I certify that I understand	IL&I V		D ADDRESS (IDED (If other t				SERVICES		33. PHYSICIAN'S, AND PHONE	, SUPPLIE		ING NA	ME, ADDI	RESS, ZIP CODE
billing instructions, that information conta with those instructions and accurate to the	ined on this bill is consisten					/									
SIGNED	ı	DATE								PIN#		1	GRP#		



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

PLEASE PRINT OR TYPE

	PICA													P	ICA T
1.	TION								L&I (ID)	1a. INSURED'S I				OGRAM IN	N ITEM 1)
2. PATIENT'S N	NAME (Last N	ame, F	irst Name,	Middle Ir	nitial)	3. PA	TIENT'S BIRTH D	ATE	SEX	4. INSURED'S N	AME (Last	Name, F	irst Nam	e, Middle	Initial)
Doe, Ja						X	x xx xx	м							
5. PATIENT'S A						6. PA	TIENT RELATION	ISHIP TO I	NSURED	7. INSURED'S AI	DDRESS (No., Stree	et)		
151 Oal	k Creel	k La	ane		Lot	_	Spouse (Child	Other	0.77					LOTATE
Morton					W	ATE 8. PA	TIENT STATUS Married	d 🔲	Other	CITY					STATE
ZIP CODE 98519			HONE (Inc		,	Emplo	oyed Full-Tim	ne Par t Stu	t-Time	ZIP CODE	TEL	EPHONE	(Include	e Area Co	ode)
9. OTHER INSU	JRED'S NAM	E (Last	Name, Fir	st Name,	Middle Ini	,	PATIENT'S CON	DITION RE		11. INSURED'S F					
a. OTHE	R INSURED'S	S POLI	CY OR GR	OUP NU	MBER	a. EM	PLOYMENT? (CU	-	R PREVIOUS)	a. INSURED'S DA	ATE OF B		//	, .,	SEX
	R INSURED'S	S DATE	OF BIRTH	1	SEX	b. AU	TO ACCIDENT?	NO PI	ACE (State)	b. EMPLOYER'S			L NAME	IVI	
c. EMPLO	 OYER'S NAM	IE OR S	SCHOOL N	IAME	□ F	С. ОТ	HER ACCIDENT?			c. INSURANCE F	LAN NAM	y IE OR PR	OGRAN	1 NAME	
d. INSUR	RANCE PLAN	NAME	E OR PRO	GRAM N	AME	10d. F	RESERVED FOR I	LOCAL US	E	d. IS THERE AND					ata itam 0 a d
12. PATIENT'S	OR AUTHOR	RIZED F	PERSON'S	SIGNAT	URE – I ai	uthorize the re	elease of any medi	ical or othe	r information	13. INSURED'S					ete item 9 a-d. TURE – I
	o process this ignment belov		I also requ	est paym	ent of gov	ernment bene	fits either to myse	If or to the	party who	authorize paymer or supplier for ser				undersign	ed physician
SIGNED						DATE				SIGNED					
14. DATE OF C	YY	IN	LNESS (Fi	cident) Ol			ENT HAS HAD SAME FIRST DATE	E OR SIMILA MM DE		16. DATES PATII MM FROM		BLE TO W	ORK IN		NT OCCUPATION DD YY
XX XX 17. NAME OF R			REGNANC		OURCE	17a. I.D. N	NUMBER OF REF	ERRING P	HYSICIAN	18. HOSPITALIZA	ATION DA	TES TO		NT SERVI	CES
Xxxxxx						0000				MM		YY			DD YY
19. RESERVED						0000	000			FROM 20. OUTSIDE LA	B?		ТО	\$ CH/	ARGES
] _{NO}	1		*	1
		E OF IL	LNESS OI	R INJUR'	•		, 3 OR 4 TO ITEM	24E BY LI	NE)	22. MEDICAID RI CODE	ESUBMIS	SION	ORIG	INAL REF	F. NO.
1. XXX.)						·-	_			23. PRIOR AUTH	ORIZATIO	ON NUMB	ER		
					1										T V
24. A	OF SERVICE		B	C Type Of	PPO	CEDI IDES S	ERVICES OR SUF	DDI IES	Е	F	G	H	1	J	К
MM DD YY			OF SERVICE	Of Service			sual Circumstance MODIFII	s)	DIAGNOSIS CODE	\$ CHARGES	Or Units	Family Plan	EMG	COB	RESERVED FOR LOCAL USE
01 01 02	01 01 0	2	24	3		XXXXX	SG X	x	XXX.XX	XXX XX	1				
1 1							1 1								
1 1							1 1								
	1 1									I					
25. FEDERAL T		BER	SSN	-	Optic	ent's accol nal	JNT NO.		YES NO	28. TOTAL CHAR		29. AMOU	NT PAII)	30. BALANCE DUE
31. PHYSICIAN/S DEGREES OR CR billing instructions, that	UPPLIER SIGNA EDENTIALS — (information containe	I certify tha	at I understand L		32. NAME	AND ADDRE	ESS OF FACILITY other than home or		SERVICES	\$ XXX 33. PHYSICIAN'S AND PHONE Ambulatory Surge	, SUPPLIE #		ING NA	ME, ADDI	L RESS, ZIP CODE
with those instructions a WWWWWWWW SIGNED	and accurate to the b	est of my	knowledge.)	/XX ATE						3112 Xxxxxxxx La Morton WA 9851 PIN # 000000	ine 9 (360) 00		GRP#	0000000)



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

Sample: ASC

WITH IMPLANT PLEASE PRINT OR TYPE

	PICA	r	LLAJL	FRINIC	/K I II L										PI	CA T	
1.	FICA								L&I	1a. INSUF	RED'S I	D. NUMB	ER (F	OR PRO	OGRAM IN	NITEM 1)	
									(ID)	000-0	0-0 C	0000	(SSN	1)			
2. PATIENT'S N	IAME (Last Nam	ne, First Name,	Middle Init	al)	3. PATIE	NT'S BIR	TH DATE		SEX	4. INSUR	ED'S N	AME (Last	Name, Fi	irst Nam	e, Middle	Initial)	
Doe, Ja	ne				XX	XX	XX	Г									
,							M	L	F								
5. PATIENT'S A					6. PATIE	NT RELA	TIONSHIP	TO II	NSURED	7. INSUR	ED'S AI	DDRESS (No., Stree	et)			
151 Oal	k Creek	Lane			Self	Spouse	Child		Other								
CITY				STATE	8 PATIE	NT STAT	US			CITY						STATE	
Morton				WA						0						0.7.12	
ZIP CODE	Гтс	LEPHONE (Inc	Judo Aroo		Single	∐ N	Married		Other	ZIP CODE		TEI	EDHONE	(Include	e Area Co	do)	
98519		360) 000		•	Employe		ull-Time	Part	-Time	ZIF CODE	=	(.EFHONE)	: (IIICIUU	e Alea Co	ue)	
9. OTHER INSU					40 10 0		tudent L		dent LJ LATED TO:	11. INSUF	DEDIO F	,	,	D FF04	NUMBER		
9. OTHER INSC	JRED S NAME (Last Name, Fir	st name, iv	liddle milial)	10. 15 P	ATIENT S	CONDITIO	NKE	LATED TO:				_				
					a. EMPL	OYMENT	? (CURREN	NT O	R PREVIOUS)	Y 00				IIII #)		
a. OTHE	R INSURED'S P	OLICY OR GR	OUP NUM	BER		YES	S NO			a. INSURI	ED'S DA DD		RIH			SEX —	
					h ALITO	ACCIDE	NT2	PI	ACE (State)		1				M	□ _F □	
	R INSURED'S D DD YY	ATE OF BIRTH	1	SEX	2171010	YES				b. EMPLC				L NAME			
			М		C OTHE	ER ACCID	ENT?			XYZ							
c. EMPL	OYER'S NAME	OR SCHOOL N	IAME		0.0111	YE				c. INSUR	ANCE F	LAN NAM	IE OR PR	OGRAN	1 NAME		
						ш											
d. INSUR	RANCE PLAN N	AME OR PRO	GRAM NAI	ΛE	10d. RE	SERVED	FOR LOCAL	L US	E	d. IS THE						- t - it 0 d	
											YES [NO	If yes, re	turn to a	ina comple	ete item 9 a-d.	
12. PATIENT'S										13. INSUI							
	o process this cla ignment below.	aim. I also requ	est payme	nt of governn	nent benefits	either to	myself or to	the	party who	authorize or supplie					undersign	ed physician	
docopio doc	igninent below.									от заррно	1 101 301	vioco doo	oribed bei	OW.			
SIGNED				D	ATE					SIGNED							
14. DATE OF C	LIDDENT.	ILLNESS (Fi					SAME OR SI		D II I NEOO			-NIT LINIAE	DI E TO W	/ODK IN	CUDDEN	NT OCCUPATION	
MM DD		INJURY (Acc		II) OR	GIVE FIR			IMILA DE		IO. DATE	S PATII		YY YY	VORK IIV		DD YY	JIN
$XX \mid XX$	XX	PREGNANC	Y (LMP)					l		FROM	1	1		TO	- 1		
17. NAME OF F	REFERRING PH	YSICIAN OR O	THER SO	JRCE 1	7a. I.D. NU	MBER OF	REFERRIN	NG P	HYSICIAN	18. HOSP				CURRE			
										FROM	MM 1	DD I	YY I	TO	MM	DD YY	
19. RESERVED	FOR LOCAL U	SE		•						20. OUTS	IDE <u>LA</u>	B?	•		\$ CHA	ARGES	
										│	s L	J _{NO}	1			1	
21. DIAGNOSIS	OR NATURE C	OF ILLNESS OF	R INJURY.	(RELATE IT	EMS 1, 2, 3	OR 4 TO	ITEM 24E E	3Y LI	NE)	22. MEDIO	CAID R		SION			-	
1.				3					Ţ	CODE			1	ORIG	INAL REF	. NO.	
				0.						23. PRIO	R AUTH	ORIZATIO	ON NUMB	BER			
2.				4.													
				**													
24. A		В	С			D			E	F		G	Н	1	J	K	
DATE(S)	OF SERVICE	PLACE OF	Type Of				R SUPPLIE	S	DIA GNIGGIG			Days Or	EPSDT Family	EMG	СОВ	DE0ED\/E	
MM DD YY	MM DD YY	SERVICE	Service		lain Unusua HCPCS		stances) ODIFIER		DIAGNOSIS CODE	\$ CHAR	GES	Units	Plan			RESERVED LOCAL U	
01 01 02	01 01 02	24	3	XXX	ΚXX	SG	XX		XXX.XX	XXX	XX	1					
04 : 041 05	04.041.02	0.4	_						vvv vv	1000	\/\'						
01 01 02	01 01 02	24	3	XXX	ΚXX	SG			XXX.XX	XXX	XX	1					
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' '			11/11 1	ANTIIC	i CS COI	Æ	-										
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, ,						ı	ı				ı						
25. FEDERAL T	AX I.D. NUMBE	R SSN	EIN 2	6. PATIENT'S	S ACCOUN	T NO.	27. AC	CCEPT	ASSIGNMENT?	28. TOTAL	CHAR	GE 2	9. AMOU	INT PAIL)	30. BALANCE	DUE
			E 2					٦.	res No								
00-0000	0000		$X \mid C$	Optiona	al		_	- \	IES - NO	\$	XXX I	xx s	3		1	\$	- 1
31. PHYSICIAN/S	UPPLIER SIGNATI	JRE INCLUDING		2. NAME AN		S OF FAC	ILITY WHE	RE S	ERVICES			707		ING NA	ME, ADDI	I RESS, ZIP COI	DE
	EDENTIALS - (I ce	rtify that I understand L		/ERE PROVI						AND F	HONE	#					
	and accurate to the best									Ambulator 3112 Xxxx							
wwwwww	wwwwwww	www xx/xx	/XX							Morton W	4 9851	9 (360) 00		000			
SIGNED		_	ΔTF							PIN#	000000	1	- 1	GRP#	0000000	1	



L&I HEALTH INSURANCE CLAIM FORM

Sample: ASC

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

INJECTION PLEASE PRINT OR TYPE **PROCEDURE**

1.	PICA						Г	L&I (ID)	1a. INSURED'S I		,			N ITEM 1)
2. PATIENT'S N	NAME (Last Name	e, First Name,	Middle In	itial)	3. PATIENT'S BIRTH D	ATE	_	SEX	4. INSURED'S NA				ne, Middle	Initial)
Doe, Ja					XX XX XX	М] _F 🗓						
	ADDRESS (No., S				6. PATIENT RELATION	ISHIP T	01	NSURED	7. INSURED'S AI	DDRES	S (No., Stre	eet)		
151 Oal	k Creek L	_ane			Self Spouse	Child		Other						
CITY				STATI					CITY					STATE
Morton				WA	Single Marrie	d 🗌		Other						
ZIP CODE		EPHONE (Inc			Employed Full-Tir	me┌┐[Par	t-Time	ZIP CODE	T	ELEPHON \	E (Includ	e Area Co	de)
98519	JRED'S NAME (L	60) 000			Employed Full-Tir Studen 10. IS PATIENT'S CON				44 100 105010	()	D 5504		
9. OTHER INSU	JRED'S NAME (L	ast Name, Firs	st Name,	ivildale initial					11. INSURED'S F					
a. OTHE	R INSURED'S PO	OLICY OR GR	OUP NUI	MBER	a. EMPLOYMENT? (CU	_	ГΟ	R PREVIOUS)	a. INSURED'S D			XIIII #	-)	SEX
J. V						NO			MM DD				М	□ _F □
	R INSURED'S DA	ATE OF BIRTH	1	SEX	b. AUTO ACCIDENT?		PL	ACE (State)	b. EMPLOYER'S			OL NAME		<u> </u>
MM E	DD YY		М			_		II	XYZ Cor					
c. EMPL	OYER'S NAME C	R SCHOOL N	AME		C. OTHER ACCIDENT	ON 🗎			c. INSURANCE F	PLAN NA	AME OR PI	ROGRAN	/ NAME	
d. INSUF	RANCE PLAN NA	AME OR PROC	GRAM NA	AME	10d. RESERVED FOR	LOCAL	US	E	d. IS THERE AND	OTHER NO	HEALTH B	ENEFIT eturn to a	PLAN? and comple	ete item 9 a-d.
necessary to					orize the release of any med ment benefits either to myse				13. INSURED'S (authorize paymer or supplier for ser	nt of me	dical benef	its to the		
SIGNED				ı	DATE				SIGNED					
14. DATE OF C		ILLNESS (Fir		om) OR	15. IF PATIENT HAS HAD SAM	E OR SIM			16. DATES PATII			WORK IN		NT OCCUPATION
MM DD XX XX		INJURY (Acc PREGNANC		8	GIVE FIRST DATE	MM I	DE) YY	FROM MM	l D	D YY	то	MM	DD YY I
17. NAME OF F	REFERRING PHY	SICIAN OR O	THER SO	DURCE	17a. I.D. NUMBER OF REF	ERRING	G P	HYSICIAN	18. HOSPITALIZA			CURRE		
	Xxxxxx N				0000000				FROM MM		D YY	ТО	1	DD YY
19. RESERVED	FOR LOCAL US	SE							20. OUTSIDE LA	1			\$ CHA	ARGES
21. DIAGNOSIS	OR NATURE O	F ILLNESS OF	RINJURY	'. (RELATE I	TEMS 1, 2, 3 OR 4 TO ITEM	1 24E BY	/ LI	NE)	22. MEDICAID R		ISSION			
1. XXX.X	(X			2				Ţ	CODE			ORIG	INAL REF	. NO.
2.					·				23. PRIOR AUTH	IORIZA ⁻	TION NUM	BER		
24. A		В	С	7.	D			E	F		1			I K
	OF SERVICE	PLACE OF	Type Of	PROCE	DURES, SERVICES OR SU	PPI IFS		E .	Г	G	H	ı	J	^
MM DD YY		OF SERVICE	Of Service	(E:	cplain Unusual Circumstance F/HCPCS MODIFI	es)		DIAGNOSIS CODE	\$ CHARGES	Or Units	Family Plan	EMG	COB	RESERVED FOR LOCAL USE
01 01 02	01 01 02	24	3		evel XXXX SG			XXX.XX	XXX XX	1				
01 01 02	01 01 02	24	3		XXXX SG 50	0		XXX.XX	Full charge XXX XX	1				
01 01 02	01 01 02	24	3		evel XXXX SG			XXX.XX	XXX XX	1				
01 01 02	01 01 02	24	3	XX	(XXX SG 50	0		XXX.XX	Full Charge XXX XX	1				
01 01 02	01 01 02	24	3	76	005 TC			XXX.XX	XXX XX	1				
1 1	1 1				1 1									
25. FEDERAL T	AX I.D. NUMBER	R SSN	EIN	26. PATIENT	'S ACCOUNT NO.	27. ACC	CEPT	ASSIGNMENT?	28. TOTAL CHAR	GE	29. AMO	UNT PAI	D	30. BALANCE DUE
00-0000				Option		igsqcup		YES NO	\$ XXXX		\$		1	\$
DEGREES OR CR billing instructions, that	UPPLIER SIGNATUREDENTIALS — (I certi information contained on the containe	fy that I understand Lithis bill is consistent			ND ADDRESS OF FACILITY /IDED (If other than home of		ES	SERVICES	33. PHYSICIAN'S AND PHONE Ambulatory Surge	# ery Cent		LING NA	ME, ADDI	RESS, ZIP CODE
	wwwwwwwww		'XX						3112 Xxxxxxxx La Morton WA 9851					
SIGNED	*******		ATE						PIN # 000000			GRP#	0000000)



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269

PLEASE PRINT OR TYPE Sample: Anesthesiologist

	PICA		ILLASL	. / ////	TORTIFE SEE P				O				PI	CA	
1.								L&I (ID)	1a. INSURED'S I		,		OGRAM IN	I ITEM 1)	
2. PATIENT'S N	NAME (Last Name	e. First Name,	Middle Init	ial)	3. PATIENT'S BIRTH D	ATE		J ` ′ SEX	4. INSURED'S N				e, Middle	Initial)	
Doe, Ja	ne				MM DD YY	М		$_{F}\mathbf{X}$,	,				
	ADDRESS (No., S k Creek L	,			6. PATIENT RELATION Self Spouse		_	NSURED Other	7. INSURED'S AI	DRESS (No., Stree	et)			
CITY				STA					CITY					STATE	
Morton ZIP CODE	T TEL	EPHONE (Inc	lude Area	Code)	A Single Marrie	d 🗌		Other	ZIP CODE	T TEL	EPHONE	(Include	- Area Co	da)	
98519	(3	60) 000	0-000	0	Employed Full-Tin					()	`		,	
9. OTHER INSU	JRED'S NAME (L	ast Name, Fire	st Name, IV	liddle Initi					11. INSURED'S F						
a. OTHE	R INSURED'S PO	DLICY OR GR	OUP NUM	BER	a. EMPLOYMENT? (CL	_	T Oi	R PREVIOUS)	a. INSURED'S DA	ATE OF B		1111 77		SEX	
	R INSURED'S DA	ATE OF BIRTH	1		b. AUTO ACCIDENT?	ON [PL	ACE (State)	b. EMPLOYER'S	NAME OF	R SCHOO	L NAME	<u>M</u>	<u> </u>	
SEX MM [DD YY			□ _F [_	J		lI	XYZ Cor	npan	y				
c. EMPLO	OYER'S NAME O	R SCHOOL N	IAME	<u> </u>	YES				c. INSURANCE F	LAN NAM	IE OR PR	OGRAN	1 NAME		
d. INSUR	RANCE PLAN NA	ME OR PRO	GRAM NAM	ИE	10d. RESERVED FOR	LOCAL	.US	E	d. IS THERE AND	_				ete item 9 a-d.	
					thorize the release of any medi rnment benefits either to myse				13. INSURED'S (authorize paymer	nt of medic	al benefit	s to the			
	ignment below.		, -	-				,	or supplier for ser						
SIGNED					DATE				SIGNED						
14. DATE OF C MM DD		ILLNESS (Fir	cident) OR		15. IF PATIENT HAS HAD SAMI GIVE FIRST DATE			R ILLNESS. YY	16. DATES PATII		YY		MM I		N
	REFERRING PHY		Y (LMP) THER SO	URCE	17a. I.D. NUMBER OF REF	ERRIN	GΡ	HYSICIAN	FROM 18. HOSPITALIZA		TES TO				
	Xxxxxx N				0000000				FROM	-	YY 	то	MM I	1	
	FOR LOCAL US								20. OUTSIDE LA] _{NO}			\$ CH#	ARGES	
21. DIAGNOSIS	OR NATURE O	F ILLNESS OF	R INJURY.	(RELATE	ITEMS 1, 2, 3 OR 4 TO ITEM	1 24E B	Y LII	NE)	22. MEDICAID RI CODE	ESUBMIS	SION	ORIG	INAL REF	. NO.	
1. XXX	XX			3	·			*	23. PRIOR AUTH	ORIZATIO	ON NUMB	ER			
2.	-·			4.	·										
24. A		В	С		D			E	F	G	Н	I	J	K	
DATE(S) (OF SERVICE MM DD YY	PLACE OF SERVICE	Type Of Service	(1	EDURES, SERVICES OR SUI Explain Unusual Circumstance PT/HCPCS MODIFI	es)	8	DIAGNOSIS CODE	\$ CHARGES	Days Or Units	EPSDT Family Plan	EMG	СОВ	RESERVED F LOCAL USI	
03 01 01	03 01 01	XX	3	×	XXXXX XX			XXX.XX	XX XX	20 Min.					
1 1					1 1										
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		R SSN	FIN. L 2	DATIE!	 NT'S ACCOUNT NO.	27 AC	CEPT	ASSIGNMENT?	L 20 TOTAL CHAR	CE L	29. AMOU	NT DAI		30. BALANCE DU	ıc T
00-0000	TAX I.D. NUMBEF		T 7	Optio			1	ES NO	28. TOTAL CHAR	Ĭ .		INT PAIL	ا	\$	
31. PHYSICIAN/S DEGREES OR CR billing instructions, that	SUPPLIER SIGNATUR EDENTIALS — (I certiful information contained on the con	RE INCLUDING ify that I understand L this bill is consistent	3	2. NAME	AND ADDRESS OF FACILITY OVIDED (If other than home or			ERVICES	33. PHYSICIAN'S AND PHONE Xxxxxx Xxxxxxxx	, SUPPLIE #	ER'S BILL	ING NA	ME, ADDI	RESS, ZIP CODE	≣
with those instructions a	and accurate to the best of	my knowledge.)							3112 Xxxxxx Lane Morton, WA 9851)) XXX-XX	YY			
									Wichton, WA 3031	3 (XXX		^//			



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

Sample: Chiropractor PLEASE PRINT OR TYPE

	PICA		,	LLASI	- 1 /\1	IVI OK	11 L		P		• F -						D	ICA I	
1.	TICA										L&I		1a. INSURED'S I.	D. NUMBI	ER (F	OR PRO	OGRAM IN	N ITEM 1)	
											(ID)		000-00-0	000 ((SSN	I)			
2. PATIENT'S N	•	lame, F	First Name,	Middle In	tial)	3	. PATIENT	'S BIRTH	1 DATE		SEX		4. INSURED'S NA	ME (Last	Name, F	irst Nam	ne, Middle	Initial)	
Doe, Ja	ne						MM E	D YY		Г] _F 🛛								
5. PATIENT'S A	ADDRESS (No	n Stre	et)			6	. PATIENT	REI ATI					7. INSURED'S AD	DRESS (No Stree	et)			
151 Oal	(. ,	,			_	elf Sp	_	_	_			7. 114001122 0 712	DILLOO (140., 0110	ot)			
	Cleci	\ _C	al IC							Ш	Other								
CITY							. PATIENT	STATUS	3				CITY					STATE	
Morton						WA s	ingle	Mar	ried 🔲		Other								
ZIP CODE			PHONE (Incl)	mployed I	→ Full-	Time	ı Part	-Time \square		ZIP CODE	TEL /	EPHONE	(Includ	e Area Co	ode)	
98519			0) 000				mployed							()				
9. OTHER INSU	JRED'S NAM	E (Las	t Name, Firs	st Name,	Middle	Initial) 1	0. IS PATI	ENT'S C	ONDITIO	N RE	LATED TO:		11. INSURED'S P						
							. EMPLOY	MENT? (CURREN	NT OI	R PREVIOUS	3)	Y 000000			aim a	#)		
a. OTHE	R INSURED'S	S POLI	ICY OR GR	OUP NUI	//BER		Г	YES	□ NO				a. INSURED'S DA		RTH			SEX	
						ь	. AUTO AC	- CIDENT	?	PL	ACE (State)	L	1	1			M	\sqcup _F \sqcup	
SEX D. OTHE	R INSURED'S	SDAII	E OF BIRTE	1			Г	YES	□ NO				b. EMPLOYER'S			L NAME	=		
MM [DD YY					$_{F} \square \mid c$	OTHER	- ACCIDEN	NT?				XYZ Con	npan	y				
c. EMPL	OYER'S NAM	1E OR	SCHOOL N			-		YES	☐ NO			F	c. INSURANCE P	LAN NAM	E OR PR	OGRAN	/ NAME		
d. INSUF	RANCE PLAN	NAM	E OR PROC	GRAM NA	ME	1	0d. RESEF	RVED FC	R LOCA	L US	E		d. IS THERE AND	THER HE	ALTH BE	ENEFIT	PLAN?		
													YES	NO	If yes, re	turn to a	and compl	ete item 9 a-d.	
12. PATIENT'S	OR AUTHOR	RIZED I	PERSON'S	SIGNATI	JRE –	I authorize t	he release	of any m	edical or	othe	r information		13. INSURED'S C	R AUTHO	DRIZED F	PERSON	'S SIGNA	TURE – I	
	o process this ignment below		. I also reque	est payme	ent of	government	benefits eit	her to my	self or to	the p	party who		authorize paymen or supplier for ser				undersign	ed physician	
accepts ass	igililetit belov	vv.											or supplier for ser	vices desc	ilibed bei	Ow.			
SIGNED						DATE							SIGNED						
14. DATE OF C	IIRRENT:	II	LNESS (Fir	et symnto	m) OF		PATIENT H			ΙΜΙΙ Δ	RILLNESS	_	16. DATES PATIE		RI E TO W	/ORK IN	I CURREN	NT OCCUPATION	_
MM DD			NJURY (Acc	ident) OR			VE FIRST				YY		MM		YY		MM		
17. NAME OF F	EFFERRING I	PHYSI	REGNANCY	Y (LMP) THER SC	URCE	= 17a	D NUMB	FR OF R	FFFRRIN	NG P	 HYSICIAN	_	FROM 18. HOSPITALIZA	TION DA	TES TO (TO	NT SERVI	CES	
Xxxxxx				THE IT OC	ONOL		0000		LI LIW		11101017114		MM	DD			MM		
19. RESERVED						00	00000					_	FROM 20. OUTSIDE LAB			ТО	\$ CH/	ARGES	
1011120211122		- 002											YES	1			Ψ 0.1.		
21. DIAGNOSIS	S OR NATURI	F OF II	LLNESS OF	RINJURY	(RFI	ATE ITEMS	1 2 3 OR	4 TO IT	FM 24F F	RY I II	NF)	-	22. MEDICAID RE		SION				
		_ 0			. (, <u> </u>	· · · · · · · · · · · · · · · · · · ·		CODE			ORIG	INAL REF	. NO.	
1. XXX.	XX				3.		·				•	-	23. PRIOR AUTH	ORIZATIO	I N NUMB	BER			
2.					4.	l	·												
24. A			В	С			D				Е		F	G	Н	ı	J	K	
DATE(S)	OF SERVICE		PLACE OF	Type	PI	ROCEDURE	S, SERVIC	ES OR S	SUPPLIE	S				Days Or	EPSDT Family	EMG	COB		
MM DD YY	MM DD \	~	SERVICE	Service		(Explain CPT/HCP	Unusual C	ircumstar MOD			DIAGNOSIS CODE	S	\$ CHARGES	Units	Plan	LINIO	COB	RESERVED FO LOCAL USE	
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													1						
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	I I	חבים	0011	FINI 1		TIENT'S AC			27 1	CCEPT	ASSIGNMENT?		20 TOTAL OUAS	OF 1 ^	9. AMOU	NIT DA		30. BALANCE DUE	
25. FEDERAL 1	AX I.D. NUM	BEK	SSN		_		COUNTN	U.	27. AC	7			28. TOTAL CHAR	GE 2	y. AMOU	INT PAII	U		-
00-0000	0000			$\overline{\mathbf{X}}$	υþ	tional				۱ ر	res L NO		\$ XX >	(X \$;		-	\$	1
31. PHYSICIAN/S		ATURE	INCLUDING			ME AND AD					SERVICES	+	33. PHYSICIAN'S,		R'S BILL	ING NA	ME, ADDI	RESS, ZIP CODE	
DEGREES OR CR				&I	WERE	PROVIDED	(If other th	nan home	or office	e)			AND PHONE #						
with those instructions a													3112 Xxxxxx Lane						
													Morton, WA 9851 PIN # 0000000	9 (XXX)) XXX-XX		P# 0000	000	
SIGNED XXX	XXXXX	DA [*]	TE XX/XX/	XX								1	1 11 m 00000000			1 GK	. # 0000	000	



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

Sample: CRNA PLEASE PRINT OR TYPE

	PICA	,	LLAS	LIN	IIVI OF			1								Р	ICA
1.										L&I (ID)		1a. INSURED'S I				OGRAM II	N ITEM 1)
a DATIENTIA	144F (1 4 4 1	F:		1		o DATIENT	O DIDTI I		L			000-00-0					1 12 B
Doe, Ja			ivilaale ir	nitiai)		3. PATIENT	D YY			SEX		4. INSURED'S NA	AME (La:	st Name, F	irst Nan	ie, ivilaale	initiai)
	NDDRESS (No., S Creek L	,				6. PATIENT	_		_			7. INSURED'S AL	DDRESS	(No., Stre	et)		
CITY					STATE	8. PATIENT	STATUS					CITY					STATE
Morton					WA	Single	Marrie	ed 🗌		Other							
ZIP CODE 98519		60) 000			e)	Employed [Full-Tir	me	Part	t-Time		ZIP CODE	TE (LEPHONE)	E (Includ	e Area Co	ode)
	JRED'S NAME (La				e Initial)					dent LATED TO:		11. INSURED'S F	OLICY (GROUP OI	R FECA	NUMBER	1
	,	,			,	a EMPLOY	MENT? (CI	IRREN	IT OI	R PREVIOUS	S)	Y 00000) (L8	& I Cla	aim :	#)	
a. OTHE	R INSURED'S PO	DLICY OR GR	OUP NU	MBER			YES	NO				a. INSURED'S DA		BIRTH		М	SEX F
b. OTHE	R INSURED'S DA	TE OF BIRTH	1			b. AUTO AC	CCIDENT?		PL	ACE (State)		b. EMPLOYER'S			DL NAMI	- ···	•
	DD YY			П	_F	C. OTHER		_				XYZ Cor	npar	ıy			
c. EMPLO	OYER'S NAME O	R SCHOOL N			<u> </u>		YES	NO				c. INSURANCE P	LAN NA	ME OR PR	ROGRAN	/ NAME	
d. INSUR	RANCE PLAN NA	ME OR PRO	GRAM N	AME		10d. RESER	RVED FOR	LOCAL	US	E		d. IS THERE AND					ete item 9 a-d.
necessary to	OR AUTHORIZED process this clais ignment below.											13. INSURED'S (authorize paymer or supplier for ser	nt of med	ical benefi	ts to the		
OLONED					5.47							0101155					
SIGNED	IIRRENT:	ILLNESS (Fi	ret symnt	om) O		E		IF OR SI	MII Δ	R II I NESS		SIGNED		ARI E TO V	VORK II	I CURRE	NT OCCUPATION
MM DD	YY	INJURY (Acc	ident) Ol	R		GIVE FIRST				YY		FROM			TO	MM	
	EFERRING PHY	SICIAN OR O	THER S	OURC		a. I.D. NUMB		ERRIN	IG P	HYSICIAN		18. HOSPITALIZA	DE	ATES TO		NT SERV	
	FOR LOCAL US											20. OUTSIDE LA			10	\$ CH/	ARGES
04 DIAONIOGIO	OD MATURE OF) IN II ID	V (DE		10.4.0.000	4 TO ITEM	104E D	V I II	NIE'		LI YES L					1
1. XXX.)	OR NATURE OF	- ILLINESS OF	K INJUK	Y. (KE			4 IOIIEN	1 24E B	Y LII	NE)	l	22. MEDICAID RI CODE	ESORIVII	SSION	ORIG	INAL REF	F. NO.
1. ^^.	^^			3.								23. PRIOR AUTH	ORIZAT	ION NUME	BER		
2.	·			4.		·											
24. A		В	С			D				Е		F	G	Н	ı	J	К
DATE(S)	OF SERVICE	PLACE OF	Type Of	Р		RES, SERVIC			3				Days Or	EPSDT Family	EMG	СОВ	
MM DD YY	MM DD YY	SERVICE	Service		(Expla	in Unusual C CPCS	ircumstance MODIF			DIAGNOS CODE	IS	\$ CHARGES	Units	Plan			RESERVED FOR LOCAL USE
03 01 01	03 01 01	XX	N		XXX	XX	XX			XXX.XX		XX XX	1				
03 01 01	03 01 01	XX	N		XXX	XX	XX			XXX.XX		XX XX	1				
1 1	1 1					1	1										
												I					
1 1	1 1					1	ı					ı					
25. FEDERAL T	AX I.D. NUMBER	SSN				ACCOUNT N	O.	27. AC	CEPT	ASSIGNMENT?		28. TOTAL CHAR	GE	29. AMOL	JNT PAI	D D	30. BALANCE DUE
00-0000	0000		$\overline{\mathbf{X}}$	Op	tiona] ,	res 🗆 NO)	\$ XX 2	xx	\$		1	\$
	UPPLIER SIGNATUR					ADDRESS O				SERVICES		33. PHYSICIAN'S	, SUPPL	IER'S BILI	ING NA	ME, ADD	RESS, ZIP CODE
DEGREES OR CR billing instructions, that it	EDENTIALS — (I certif	y that I understand L				ED (If other the						AND PHONE Xxxxxx Xxxxxxx	#			-	
with those instructions a	and accurate to the best of	my knowledge.)										3112 Xxxxxx Lane Morton, WA 9851)	X) XXX-XX	ΧX		
SIGNED XXX		ATE XX/XX/										PIN # 0000000	- (757	,	GF	RP# 0000	
(APPROVED BY f245-127-000	AMA COUNCIL (3/92)	ON MEDICAL	SERVIC	CES 8/8	(8)					L&I	PRO	VIDER ACCOUNT #	+	FC FC	ORM HO	FA-1500 (CP-1500]	12-90) FORM RRB-1500 Page 22
																	Page 22



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

Sample: Hospital ER/Prof Sycs PLEASE PRINT OR TYPE

	PICA		Г	LLASL	. FKI	INIOK	IIFL	Dan	ipic.	110	spitai i			•			D	ICA TITLE
1.	FIOA										L&I		1a. INSURED'S I.	D. NUMB	ER (F	OR PRO	OGRAM IN	N ITEM 1)
											(ID)		000-00-0	000	(SSN	l)		
2. PATIENT'S N	,	ame, F	irst Name,	Middle Init	tial)		3. PATIEN	T'S BIRT	H DATE		SEX		4. INSURED'S NA	ME (Last	Name, F	irst Nam	ne, Middle	Initial)
Doe, Ja	ne						MM	DD Y	·	Г								
5. PATIENT'S A	DDRESS (No	o., Stree	et)			-	6. PATIEN	T RELAT					7. INSURED'S AD	DRESS (No., Stree	et)		
151 Oal	k Creek	ς La	ine				Self S	pouse	Child	П	Other							
CITY							8. PATIEN						CITY					STATE
Morton						۱۸/۸			_	ı			CITY					STATE
ZIP CODE		TFI FP	HONE (Inc	lude Area			Single	∐ Ma	rried		Other	-	ZIP CODE	T TFI	FPHONE	(Includ	e Area Co	nde)
98519			OO (C			"	Employed	Full	-Time	Part	t-Time		2 0052	()	(0700.00	(40)
9. OTHER INSU						nitial)	10. IS PAT	IENT'S C	ONDITIO	N RE	LATED TO:		11. INSURED'S P	OLICY GI	ROUP OF	R FECA	NUMBER	
							a EMDLO	VMENT2	(CLIDDEN	NT OI	R PREVIOUS	2)	Y 000000) (L&	I Cla	aim a	#)	
a. OTHE	R INSURED'S	S POLIC	CY OR GR	OUP NUM	IBER		a. LIVIFLO	_	NO	VI OI	K FKL VIOUS	"	a. INSURED'S DA	TE OF BI				SEX
							L	_	_				MM DD	YY I			М	□ _F □
	R INSURED'S	DATE	OF BIRTH	1			b. AUTO A T	CCIDEN YES		PL	ACE (State)	Ī	b. EMPLOYER'S			L NAME	=	
SEX MM [DD YY				П	F 🗆	L C. OTHER				,,		XYZ Con	npan	y			
c EMPLO	 OYER'S NAM	E OR S	SCHOOL N		ш	F L	C. OTTILIK		NO			-	c. INSURANCE P	ΙΔΝΙΝΔΜ	IF OR PR	OGRAN	1 NAME	
C. LIVIF LO	JILK S NAW	LONG	SCHOOL IN	AVIL									C. INSURANCE P	LAN INAW	IL OIL FIL	OGIVAN	/ INAIVIL	
d. INSUR	RANCE PLAN	NAME	OR PROC	GRAM NA	ME		10d. RESE	RVED F	OR LOCA	L US	E		d. IS THERE AND	THER HE	EALTH BE	NEFIT	PLAN?	
														_				ete item 9 a-d.
12. PATIENT'S	OR AUTHOR	IZED F	PERSON'S	SIGNATU	JRE –	I authorize	the release	e of any n	nedical or	othe	r information		13. INSURED'S C	R AUTHO	ORIZED F	ERSON	I'S SIGNA	TURE – I
	o process this ignment belov		I also requ	est payme	ent of o	government	benefits e	ither to m	yself or to	the p	party who		authorize paymen or supplier for ser				undersign	ed physician
ассеріз азз	igriment belov	٧.											or supplier for ser	vices desc	Jibea bei	Ow.		
SIGNED						DATE							SIGNED					
14. DATE OF C	URRENT:	ILI	LNESS (Fir	st sympto	m) OF		F PATIENT I			IMILA	R ILLNESS.		16. DATES PATIE	NT UNA	BLE TO W	ORK IN	CURRE	NT OCCUPATION
MM DD	, YY		JURY (Acc REGNANC)			G	SIVE FIRST	DATE	MM	DD) YY		MM FROM	DD	YY	то	MM	DD YY
17. NAME OF R	EFERRING F	PHYSIC	CIAN OR O	THER SO	URCE	E 17a.	I.D. NUME	BER OF F	REFERRI	NG P	HYSICIAN		18. HOSPITALIZA			CURRE		
Xxxxxx	Xxxxx	(ME)			00	0000	0					FROM MM	DD I	YY I	то	MM I	1
19. RESERVED	FOR LOCAL	USE				•							20. OUTSIDE LAE	3?			\$ CHA	ARGES
													LI _{YES} L					
21. DIAGNOSIS	OR NATURE	E OF IL	LNESS OF	R INJURY.	. (REL	LATE ITEMS	5 1, 2, 3 OI	R 4 TO IT	EM 24E E	BY LII	NE)]		22. MEDICAID RE	SUBMIS	SION	ORIG	INAL REF	- NO
1. XXX.X	ίX				3.						+	٠		00174710				
													23. PRIOR AUTH	ORIZATIC	ON NUME	EK		
2.	·				4.		·											
24. A			В	С	1		D				Е		F	G	Н	ı	J	К
DATE(S)	OF SERVICE		PLACE	Туре	PI	ROCEDURI	ES, SERVI	CES OR	SUPPLIE	S				Days	EPSDT			
MM DD YY			OF SERVICE	Service		(Explain CPT/HCI	Unusual (Circumsta MOI			DIAGNOSI: CODE	S	\$ CHARGES	Or Units	Family Plan	EMG	COB	RESERVED FOR LOCAL USE
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03 01 01	03 01 0)1	XX	3		XXXX	Х	- 1			XXX.XX		XX XX	1				
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					\vdash					\vdash			I					
1 1								1					1					
25. FEDERAL T	AX I.D. NUMI	BER	SSN	EIN 2	26. PA	ATIENT'S A	CCOUNT N	NO.	27. A	CCEPT	ASSIGNMENT?	\exists	28. TOTAL CHAR	GE 2	29. AMOU	NT PAII	D	30. BALANCE DUE
00-0000	0000			$\overline{\mathbf{X}}$	O 1	4: a.v. = 1				J 、	res No		e VV I V	,				
						tional	22222	SE E : S ::				_	\$ XX XX	\$			1	\$
31. PHYSICIAN/S DEGREES OR CR	EDENTIALS - (I	I certify tha	it I understand La			AME AND A PROVIDE					ERVICES		33. PHYSICIAN'S, AND PHONE #		:R'S BILL	ing na	ME, ADDI	RESS, ZIP CODE
billing instructions, that is with those instructions a	information contained	d on this bi	ill is consistent										Good Health Hosp 3112 Xxxxxx Lane	ital ER Ph	nysician			
													Morton, WA 9851) XXX-XX		_	
SIGNED XXX	XXXXX	DAT	E XX/XX/	xx									PIN # 0000000			GR	P# 0000	000



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

Sample: Laboratory PLEASE PRINT OR TYPE

	PICA		r	LLASL	FKI	IVI OK	IIFL	~	р.			3013					D	ICA .	1
1.	TIOA										L&I	1a. INSU	RED'S I	.D. NUMBI	ER (F	OR PR	OGRAM II	N ITEM 1)	-
											(ID)	000-	00-0	0000	(SSN	1)			
2. PATIENT'S N	•	lame, F	irst Name,	Middle Ini	tial)		3. PATIEN	T'S BIRT	H DATE		SEX	4. INSUF	ED'S N	AME (Last	Name, F	irst Nam	ne, Middle	Initial)	
Doe, Ja	ne						MM	DD Y	Υ	Г] _F 🛚								
5. PATIENT'S A	ADDRESS (No	n Stre	et)				6. PATIEN	T RELAT				7 INSUE	ED'S A	DDRESS (No Stree	et)			
151 Oal							Self S	_	_	_		7	LDON	DDINEGO (110., 0110	Ot)			
	Cleci	\	ai iC]			Ш	Other								
CITY							8. PATIEN	T STATU	JS			CITY						STATE	
Morton						WA	Single	Ma	arried]	Other								
ZIP CODE			PHONE (Inc)	Employed	┌ Ful	I-Time -	ı Pari	-Time \square	ZIP COD	E	TEL	EPHONE	(Includ	e Area Co	ode)	
98519			0) 000				Employed							()				
9. OTHER INSU	JRED'S NAMI	E (Last	t Name, Fire	st Name, N	/liddle	Initial)	10. IS PAT	TENT'S C	CONDITIO	N RE	LATED TO:			POLICY GI				1	
							a. EMPLO	YMENT?	(CURREI	NT O	R PREVIOUS)			0 (L&		ım #	F)		
a. OTHE	R INSURED'S	S POLI	CY OR GR	OUP NUM	IBER			YES	□ NO				ED'S D. I DD	ATE OF BI YY	RIH			SEX	
	D		- 05 01071				b. AUTO A	 CCIDEN	 T?	PL	ACE (State)						М	⊔ _F ⊔	
SEX B. OTHE	R INSURED'S	SDATE	OF BIRTE	1				YES						NAME OF		L NAME	=		
MM [DD YY					_F 🔲	C. OTHER	ACCIDE	NT?			AYZ	Cor	npan	y				
c. EMPL	OYER'S NAM	IE OR :	SCHOOL N			-		YES	□ NO			c. INSUR	ANCE F	PLAN NAM	E OR PR	OGRAN	/ NAME		
d. INSUF	RANCE PLAN	NAME	E OR PROC	GRAM NA	ME		10d. RESE	RVED F	OR LOCA	L US	E	d. IS THE	RE AN	OTHER HE	ALTH BE	ENEFIT	PLAN?		
													YES [NO	If yes, re	eturn to a	and compl	ete item 9 a-d.	
12. PATIENT'S	OR AUTHOR	RIZED F	PERSON'S	SIGNATU	IRE –	I authorize	the releas	e of any r	medical or	othe	r information	13. INSU	RED'S	OR AUTHO	RIZED F	PERSON	N'S SIGNA	ATURE – I	
	o process this ignment below		I also requ	est payme	nt of	governmen	t benefits e	ither to m	nyself or to	the	party who			nt of medic			undersign	ned physician	
accepts ass	igilillerit belov	w.										Oi Supplii	51 101 36	i vices desc	ilibed bei	Ow.			
SIGNED						DATE						SIGNED							
14. DATE OF C	IIRRENT:	II.	LNESS (Fir	et sympto	m) OF		F PATIENT			IMII A	RILLNESS				RI F TO W	VORK IN	I CLIRREI	NT OCCUPATIO	
MM DD		■ IN	JURY (Acc	ident) OR			SIVE FIRS				YY		MN		YY		MM		,,,
17. NAME OF F	EFFERRING F	PHYSIC	REGNANC'	Y (LMP) THER SO	LIRCE	= 17a	ID NIIM	BER OF I	REFERRI	NG P	 HYSICIAN	FROI		<u> </u> ATION DA	TES TO (CURRE	NT SERVI	ICES	
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21. DIAGNOSIS	S OR NATURE	F OF II	I NESS OF	RINJURY	(RFI	ATE ITEMS	S1 2 3 O	R 4 TO 17	FFM 24F F	3Y I I	NF)			SUBMISS	SION				
					(COD				ORIG	INAL REF	. NO.	
1. XXX	K.XX				3.		·					23. PRIC	R AUTH	IORIZATIO	N NUMB	BER			
2.	·				4.	l	- •												
24. A			В	С			D				Е	F		G	Н	I	J	K	
DATE(S)	OF SERVICE		PLACE OF	Type	PI	ROCEDUR				S				Days Or	EPSDT Family	EMG	COB		
MM DD YY	MM DD Y	_{YY}	SERVICE	Service		(Explair CPT/HC	n Unusual (PCS I	Circumsta MOI			DIAGNOSIS CODE	S \$ CHAF	GES	Units	Plan	LIVIO	COB	RESERVED LOCAL U	
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25. FEDERAL T	AX I.D. NUM	BEK	SSN		:ο. PA	TIENT'S A	CCOUNT	NU.	Z1. A	٦ .		28. TOTA	L CHAF	KGE 2	9. AMOU	INT PAI	ט		,UE
00-0000	0000			$\overline{\mathbf{X}}$	C	tional				۱ ر	res L NO	\$	XX	XX \$	i		1	\$	1
31. PHYSICIAN/S		ATURE				ME AND A	DDRESS (OF FACIL	ITY WHE	RE S	ERVICES				R'S BILL	ING NA	ME, ADD	L RESS, ZIP COD	Ε
DEGREES OR CR billing instructions, that	EDENTIALS - ((I certify the	at I understand L			PROVIDE							PHONE	#			•		
with those instructions a												3112 Xxx	xxx Lan	е					
												Morton, V PIN # (XXX-XX		P# 0000	1000	
SIGNED XXX	XXXXX	DA	TE XX/XX/	XX								FIN# (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			GR	# 0000	000	



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

Sample: Naturopath

PI PI	CA		PLEASI	E PKI	NIO	KIIPE	Sum	-р	- ''	atui op		_				D	ICA III
1.	CA									L&I		1a. INSURED'S I.				OGRAM IN	N ITEM 1)
										(ID)		000-00-0					
2. PATIENT'S NAM	•	, First Name,	Middle Ini	tial)		3. PATIE	NT'S BIRTH	DATE		SEX		4. INSURED'S NA	AME (Last	Name, Fi	irst Nam	e, Middle	Initial)
Doe, Jan	е					MM	DD YY	N									
5. PATIENT'S ADI						6. PATIE	NT RELATION					7. INSURED'S AD	DRESS (No., Stree	et)		
151 Oak	Creek L	_ane				Self	Spouse	Child		Other							
CITY				S	STATE	8. PATIE	NT STATUS	3				CITY					STATE
Morton				١.	NΑ	Single	Mari	ried	1	Other							
ZIP CODE		EPHONE (Inc				Employed	_	Time	•	_		ZIP CODE	TEL	EPHONE	(Includ	e Area Co	de)
98519		60) 000					☐ Stud	ent L	J _{Stu}	dent 🔲			()			
9. OTHER INSURI	ED'S NAME (La	ast Name, Fire	st Name, I	/liddle	Initial)	10. IS PA	TIENT'S CO	ONDITIC	N RE	ELATED TO:		11. INSURED'S F					
2 OTHER I	NSURED'S PC	NICV OR CR		IDED		a. EMPLO	OYMENT? (CURRE	NT O	R PREVIOU	S)	Y 000000			IIII #)	SEX
a. OTTILICT	NOUNLDSFC	LICT OR GR	OUF NOW	IDLIX			YES	NO				MM DD	YY	IIXIII			
b. OTHER I	NSURED'S DA	TE OF BIRTH	1			b. AUTO	ACCIDENT YES	? NO		ACE (State)		b. EMPLOYER'S	NAME OF	R SCHOO	L NAME	M	
SEX MM DD	YY							ш		II		XYZ Con	npan	У			
	ER'S NAME O	D CCHOOL N	M M	ш,	FШ	C. OTHE	R ACCIDEN					c. INSURANCE P	•		OCDAN	ANIANE	
C. EIMPLOT	ER S NAME O	K SCHOOL N	AIVIE				ш '	_				C. INSURANCE P	LAN NAW	IE OR PR	OGRAN	INAIVIE	
d. INSURAN	NCE PLAN NA	ME OR PROC	GRAM NA	ME		10d. RES	SERVED FO	R LOCA	L US	E		d. IS THERE AND	THER H	EALTH BE	NEFIT	PLAN?	
																	ete item 9 a-d.
12. PATIENT'S OF												13. INSURED'S C					
necessary to p accepts assign		m. i aiso requ	est payme	ent of g	overnme	nt benefits	eitner to my	self or to	o tne	party wno		authorize paymer or supplier for ser				unaersign	led physician
SIGNED						ΓE						SIGNED					
14. DATE OF CUR MM DD \		ILLNESS (Fir INJURY (Acc				GIVE FIRS	THAS HAD SA ST DATE	AME OR S MM				16. DATES PATIE		BLE TO W YY	ORK IN		NT OCCUPATION DD YY
17. NAME OF REF	•	PREGNANC'	Y (LMP)				MBER OF RI					FROM 18. HOSPITALIZA	TION DA		TO	IT CEDVI	
XXXXXX X			INEK SU	UKCE		00000		EFERRI	NG P	T T SICIAN		MM		YY			DD YY
19. RESERVED F						00000	30					FROM 20. OUTSIDE LAI	3?		ТО	\$ CHA	ARGES
												│ □ _{YES} □	NO NO	1			1
21. DIAGNOSIS O	R NATURE OF	FILLNESS OF	RINJURY	(RELA	ATE ITE	VIS 1, 2, 3 (OR 4 TO ITE	M 24E	BY LI	NE)	1	22. MEDICAID RE		SION	0010	555	- 110
1. XXX.)	ΧX			3.							ļ	CODE				INAL REF	·. NO.
												23. PRIOR AUTH	ORIZATIO	ON NUMB	ER		
2.				4.													
24. A		В	С			D)			E		F	G	Н	- 1	J	К
DATE(S) OF	SERVICE	PLACE OF	Type	PR			VICES OR S		S				Days	EPSDT Family	EMG	COB	
MM DD YY MI	M DD YY	SERVICE	Service		(Expla		Circumstan MOD			DIAGNOS CODE	is	\$ CHARGES	Units	Plan	Lino	005	RESERVED FOR LOCAL USE
		XX	D				•			XXX.XX		VVIVV	1				
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25. FEDERAL TAX		SSN	EIN 2	26. PA1	ΓΙΕΝΤ'S	ACCOUNT	NO.	27. A	CCEPT	ASSIGNMENT?		28. TOTAL CHAR	GE 2	29. AMOU	NT PAII)	30. BALANCE DUE
00-0000	000		\mathbf{X}	n+	iono	ı],	$_{\sf YES} \square$ $_{\sf NC}$)	\$ XX	_{XX}				¢ .
31. PHYSICIAN/SUP	PLIER SIGNATUR	RE INCLUDING			iona ME AND		OF FACILI	TY WHE	RF S	SERVICES		33. PHYSICIAN'S	,		ING NA	ME. ADDI	\$ RESS. ZIP CODE
DEGREES OR CRED billing instructions, that infor	ENTIALS - (I certify	y that I understand L					r than home					AND PHONE :	#	J DILL		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
with those instructions and a	accurate to the best of	my knowledge.)										Xxxxxx Xxxxxx, N 3112 Xxxxxx Lane					
SIGNED XXXX	VVVV -	NATE 10/20:										Morton, WA 9851 PIN # 0000000	9 (XXX) XXX-XX		P# 0000	000
	^^^	DATE XX/XX/	XX I														



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

PLEASE PRI NT OR TYPE

Sample: Osteopathic

	DICA.							-		-							104
1.	PICA									L&I (ID)		1a. INSURED'S I				OGRAM IN	ICA
2. PATIENT'S NA	ME (Last Na	mo Firet Name	Middle Ir	itial)		3. PATIE	NT'C DID	TH DATE		SEX		000-00-0 4. INSURED'S NA				o Middlo	Initial
Doe, Jan		ine, i iist Name	s, ivildale il	illai)			DD \		, \Box] _F 🔀		4. INSURED 3 N/	TIVIL (Lasi	i ivaille, i	iist ivaiii	e, iviluale	iriliai)
5. PATIENT'S AD	,	. ,				6. PATIE	NT RELA	TIONSHIP	TOI	•		7. INSURED'S A	DDRESS	(No., Stree	et)		
151 Oak	Creek	Lane]	Spouse			Other							
Morton					STATE	8. PATIE Single		US larried	1	Other		CITY					STATE
ZIP CODE 98519		360) 00			:)	Employe	d ┌┐ Fu	ull-Time	۔ Par ך	t-Time		ZIP CODE	TEI	EPHONE)	(Includ	e Area Co	de)
9. OTHER INSUF					Initial)	10. IS PA				LATED TO:		11. INSURED'S F					
2 OTHER	INIQUIDED'S	POLICY OR G	DOLID VII I	MRED		a. EMPL	OYMENT	? (CURRE	NT O	R PREVIOUS	3)	Y 00000			m #)	1	SEX
a. OTTIEK	INSUREDS	FOLIOT OR G	NOOF NO	VIDLI				S NO				MM DD	YY I			М	
b. OTHER	INSURED'S	DATE OF BIR	ГН	5	SEX	b. AUTO	ACCIDE!	NT? NO	Pl)	_ACE (State)		b. EMPLOYER'S			L NAME		
MM DE	O YY		М		_F	C. OTHE						XYZ Cor	npan	У			
c. EMPLO	YER'S NAME	OR SCHOOL	NAME				∐ YE	s NO)			c. INSURANCE P	LAN NAM	IE OR PR	OGRAM	1 NAME	
d. INSURA	ANCE PLAN	NAME OR PRO	OGRAM N	AME		10d. RES	SERVED I	FOR LOCA	AL US	E		d. IS THERE AND					ete item 9 a-d.
12. PATIENT'S Onecessary to accepts assig	process this	claim. I also red										13. INSURED'S (authorize paymer or supplier for ser	t of medic	al benefit	s to the		
CICNED					DA	ΤE						SIGNED					
SIGNED 14. DATE OF CU MM DD	IRRENT:		irst sympt	om) OF		i. IF PATIENT	T HAS HAD	SAME OR S	SIMILA		_					I CURREI	NT OCCUPATION DD YY
17. NAME OF RE		PREGNAN	CY (LMP)		E 17	a. I.D. NUN			1	1		FROM 18. HOSPITALIZA			TO		
Xxxxxx X						0000							DD			MM	DD YY
19. RESERVED I	FOR LOCAL	USE			•							20. OUTSIDE LAI	1			\$ CHA	ARGES
21. DIAGNOSIS (OR NATURE	OF ILLNESS (OR INJURY	′. (REL	ATE ITE	MS 1, 2, 3 (OR 4 TO	ITEM 24E	BY LI	NE)		YES L		SION			
1. XXX.X	Χ			3.						1		CODE				INAL REF	. NO.
2.	·			4.								23. PRIOR AUTH	ORIZATIO	ON NUME	BER		
24. A		В	С			[)			E		F	G	Н	I	J	К
DATE(S) O		PLACE OF SERVICE	Type Of Service	PI	(Expla	RES, SER' ain Unusua CPCS	l Circums		S	DIAGNOSI CODE	S	\$ CHARGES	Days Or Units	EPSDT Family Plan	EMG	СОВ	RESERVED FOR
03 01 01	03 01 01		3							XXX.XX		XX XX	1				LOCAL USE
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25. FEDERAL TA	XX I.D. NUMB	ER SS	N EIN	26. PA	TIENT'S	ACCOUNT	NO.	27. /	ACCEPT	ASSIGNMENT?		28. TOTAL CHAR	GE 2	29. AMOU	INT PAII)	30. BALANCE DUE
00-0000	000				tiona] 、	YES NO		\$ XX		6		ı	\$
31. PHYSICIAN/SUI DEGREES OR CRE billing instructions, that info with those instructions and	DENTIALS — (I d	certify that I understand on this bill is consister	L&I			ADDRESS ED (If othe				SERVICES		33. PHYSICIAN'S AND PHONE Xxxxxx Xxxxxx, D 3112 Xxxxxx Lane	# 0	ER'S BILL	ING NA	ME, ADD	RESS, ZIP CODE
SIGNED XXXX	XXXX	DATE XX/XX	//XX									Morton, WA 9851 PIN # 0000000) XXX-XX		P# 0000	000



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

Sample: Outpatient Pain Mgmt Pgm PLEASE PRI NT OR TYPE

PIC	CA	•				_	•		•		0				P	ICA
1.									L&I (ID)				SER (F		OGRAM IN	NITEM 1)
2. PATIENT'S NAM	` '	, First Name,	Middle Ini	ial)	3. PAT	IENT'S BIF	RTH DATE		SEX	4. INSUI	RED'S N	AME (Las	st Name, F	irst Nam	ne, Middle	Initial)
Doe, Jane					MM		M] _F X							
5. PATIENT'S ADD							ATIONSHIP	_	_	7. INSU	RED'S A	DDRESS	(No., Stre	et)		
151 Oak (Creek L	.ane			Self _	Spouse	Child	Ш	Other							
CITY					_	IENT STAT	TUS			CITY						STATE
Morton					/A Single		Married		Other							
ZIP CODE 98519		EPHONE (Incl 60) 000		,	Employ		ull-Time		t-Time	ZIP COL)E	(LEPHONE)	= (Includ	e Area Co	de)
9. OTHER INSURE	D'S NAME (La	st Name, Firs	t Name, N	/liddle Ini	tial) 10. IS	PATIENT'S	CONDITIO	N RE	LATED TO:				GROUP OF	– •		
					a. EMF	LOYMENT	Γ? (CURREN	IT O	R PREVIOUS)			_ \	kl Cla	ıım #	^t)	
a. OTHER IN	NSURED'S PO	LICY OR GR	OUP NUM	IBER		YE	s NO				RED'S D 1 DD	ATE OF E	BIRTH		M	SEX
b. OTHER IN	NSURED'S DA' YY	TE OF BIRTH	I	SEX	b. AUT	O ACCIDE		PL	ACE (State)			name c npar	R SCHOO	DL NAME		
c. EMPLOYE	 ER'S NAME OF	R SCHOOL N	AME M	Ш _F	C. OTH	IER ACCIE				c. INSUF	RANCE	PLAN NA	ME OR PR	ROGRAN	/ NAME	
d. INSURAN	ICE PLAN NA!	ME OR PROC	RAM NA	ME	10d. R	Ш	FOR LOCAL	L US	E	d. IS TH	ERE AN	OTHER H	IEALTH BI	ENEFIT	PLAN?	
40. DATIENTIO OD		DEDOONIO	OLONIATI	DE 1							YES [ete item 9 a-d.
12. PATIENT'S OR necessary to pr accepts assignr	ocess this clair									authorize	payme	nt of med	IORIZED Fi ical benefit scribed bel	ts to the		ed physician
SIGNED 14. DATE OF CUR	DENT.	ILLNESS (Fir	at a manta	\ OD	DATE				D.II.I.NE00	SIGNED		CNIT LINI	DI E TO V	NODK IN	LCUDDE	NT OCCUPATION
MM DD Y	Υ	INJURY (Acc	ident) OR			RST DATE	D SAME OR SI MM	MILA DE			MN					DD YY
17. NAME OF REF		PREGNANCY		URCE	17a. I.D. N	JMBER OF	F REFERRIN	 GP	HYSICIAN	FRO 18. HOS		 ATION D	ATES TO	TO CURREI	 NT SERVI	CES
Xxxxxx X					00000					FRO	MN					DD YY
19. RESERVED FO										20. OUT	SIDE LA	1		TO	\$ CHA	ARGES
21. DIAGNOSIS OF	R NATURE OF	ILLNESS OF	RINJURY	(RELAT	E ITEMS 1, 2,	3 OR 4 TO	ITEM 24E E	Y LI	NE)	22. MED		ESUBMIS	SSION			
1. XXX.XX				3.	·	=			Ţ	23. PRIC		IORIZAT	ON NUME		INAL REF	F. NO.
2.				4.		-										
24. A		В	С			D			E	F		G	Н	1	J	К
DATE(S) OF	SERVICE	PLACE OF	Type Of	PRO	CEDURES, SE	RVICES O	R SUPPLIE	S				Days Or	EPSDT Family	EMG	COB	
MM DD YY MN	M DD YY	SERVICE	Service		(Explain Unusi CPT/HCPCS		stances) ODIFIER		DIAGNOSIS CODE	\$ CHAI	RGES	Units	Plan	EMG	СОВ	RESERVED FOR LOCAL USE
03 01 01	3 01 01	XX	3		XXXXX				XXX.XX	XX	XX	1				
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	1 1						1				I					
	1 1					ı	I				ı					
25. FEDERAL TAX	I.D. NUMBER	SSN	EIN 2	6. PATIE	NT'S ACCOU	NT NO.	27. AC	CEPT	ASSIGNMENT?	28. TOT/	AL CHAF	RGE	29. AMOL	JNT PAII	D	30. BALANCE DUE
00-00000	00		$\overline{\mathbf{X}}$	Optio	onal			, ا	res NO	\$	(XXX	ıxx l	\$		ı	\$
31. PHYSICIAN/SUPF DEGREES OR CREDE billing instructions, that inform	ENTIALS — (I certify mation contained on thi	that I understand La			AND ADDRES				SERVICES	33. PHY	SICIAN'S PHONE	i, SUPPL #	IER'S BILL	LING NA	ME, ADDI	RESS, ZIP CODE
with those instructions and a		my knowledge.)								3112 Xxx	xxx Lan	e T	v) vvv vv	/YY		
SIGNED XXXXX	XXXX DA	ATE XX/XX/X	X							PIN #			X) XXX-XX		P# 0000	000



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES
CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269
Sample: Panel Examiner

PLEASE PRINT OR TYPE Sample: Panel Examine

	PICA		I LL	IJL I	KINIC	N IIIL										Р	ICA I
1.	FIOA								_	L&I		a. INSURED'S I.				OGRAM II	N ITEM 1)
										(ID)	(0-00-00	000	(SSN	1)		
2. PATIENT'S N	•	me, First Na	me, Middle	Initial)		3. PATIE	NT'S BIRTH D	DATE		SEX	4	. INSURED'S NA	AME (Las	t Name, F	irst Nam	e, Middle	Initial)
Doe, Ja	ne					MM	DD YY	м 1	Г] _F 🔀							
5. PATIENT'S A	ADDRESS (No.	, Street)				6. PATIE	NT RELATION			•	7	'. INSURED'S AE	DRESS	(No., Stree	et)		
151 Oal	k Creek	Lane				Self	Spouse	Child	٦,	Other							
CITY				-	STATE	Q DATIE	NT STATUS		_			CITY					STATE
Morton					WA		_) I I I					SIAIE
ZIP CODE	Т	ELEPHONE	(Include A	rea Coo		Single	Marrie	ed	(Other	7	IP CODE	TEI	LEPHONE	(Include	e Area Co	ode)
98519		360) C	,		40)	Employe	d Full-Tir Studer	me P	art	-Time	-	0052	()	(0700.00	,,,,,
9. OTHER INSU		,			dle Initial)		ATIENT'S CON				1	1. INSURED'S F	OLICY G	ROUP OF	R FECA	NUMBER	<u> </u>
					,	a EMDL	OYMENT? (CI	IDDENIT	. 🗥	D DDEVIOLIS	١ ١	Y 000000) (L8	d Cla	im #	<u> </u>	
a. OTHE	R INSURED'S	POLICY OF	GROUP N	UMBE	R	a. Livii L	YES	_	Oi	KT KEVIOOO)		. INSURED'S DA	TE OF B			/	SEX
						=		_				MM DD	YY I			М	
	R INSURED'S	DATE OF B	IRTH		SEX	b. AUTO	ACCIDENT?	¬ NO	PL	ACE (State)		. EMPLOYER'S			L NAME		
	OD YY			мЬ	J _F \square	C OTHE	R ACCIDENT					XYZ Con					
c. EMPL	OYER'S NAME	OR SCHO	OL NAME			C. OTTIL	YES				С	. INSURANCE P	LAN NAN	ME OR PR	OGRAN	I NAME	
d. INSUF	RANCE PLAN	NAME OR F	PROGRAM	NAME		10d. RES	SERVED FOR	LOCAL I	USI	E	d	I. IS THERE AND					ete item 9 a-d.
12. PATIENT'S	OR AUTHORI	ZED PERSO	N'S SIGNA	TURE	– I authoriz	ze the relea	se of any med	lical or ot	her	rinformation	1	3. INSURED'S C	- OR AUTH	ORIZED F	PERSON	i'S SIGNA	ATURE – I
	o process this or ignment below		request pay	ment c	of governme	ent benefits	either to myse	elf or to th	he p	party who		uthorize paymen or supplier for ser				undersign	ned physician
4000010 400	.g										ľ	. сарриот тот сот		01.200 201	••••		
SIGNED					DA	TE					. 8	SIGNED					
14. DATE OF C		ILLNES	6 (First sym	ptom) (OR 15		T HAS HAD SAM				1				VORK IN		NT OCCUPATION
MM DD	, YY		(Accident) (ANCY (LMP			GIVE FIRS	ST DATE	MM	DD) YY		MM FROM	DD I	YY I	то	MM I	DD YY
17. NAME OF F		HYSICIAN C					MBER OF REF	ERRING	PI	HYSICIAN	1	8. HOSPITALIZA					
Xxxxxx	Xxxxxx	MD			0	00000	00					MM FROM	DD 	YY 	то	MM 	DD YY
19. RESERVED	FOR LOCAL	USE									2	0. OUTSIDE LAI	3?] NO	1		\$ CH	ARGES
21. DIAGNOSIS	OR NATURE	OF ILLNES	S OR INJU	RY. (RI	ELATE ITE	MS 1, 2, 3	OR 4 TO ITEM	1 24E BY	'LII	NE)	2	2. MEDICAID RE		SION			
1. XXX.X	(X			;	3.					Ţ	2	CODE 3. PRIOR AUTH	ORIZATI	ON NUMB		INAL REF	NO.
2.	_•			4	4.												
24. A		В	ГС			Г)			E	_	F	G	Н		J	K
	OF SERVICE	PLACI		,	PROCEDI	IRES SERV	VICES OR SU	IDDI IES	4	_			Davs	EPSDT	·		
, ,		OF SERVIC	Of Service		(Expl	ain Unusua	l Circumstance	es)		DIAGNOSIS			Or Units	Family Plan	EMG	COB	RESERVED FOR
MM DD YY	MM DD Y	Y			CP1/H	ICPCS	MODIF	IER	-	CODE		\$ CHARGES					LOCAL USE
03 01 01	03 01 01	I XX	3		XXX	XX				XXX.XX		XX XX	1				
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25. FEDERAL 1	AX I.D. NUMB	ER :	SSN EIN	26. F	PATIENT'S	ACCOUNT	NO.	27. ACCI	EPT.	ASSIGNMENT?	2	8. TOTAL CHAR	GE :	29. AMOU	INT PAIL	D	30. BALANCE DUE
00-0000	0000		$\square X$	Op	otiona	I			Υ	ES NO	\$	XX I	xx :	\$		ı	\$
31. PHYSICIAN/S							OF FACILITY		E S	ERVICES		3. PHYSICIAN'S	, SUPPLI		ING NA	ME, ADD	RESS, ZIP CODE
DEGREES OR CR billing instructions, that	information contained	on this bill is consi	istent	WEF	RE PROVID	ED (If othe	r than home o	r office)			IN	AND PHONE : ME Northwest	#				
with those instructions a	and accurate to the be	st of my knowledg	в.)								3	112 Xxxxxx Lane lorton, WA 9851		() XXX-XX	'YY		
SIGNED XXX	XXXXX	DATE XX/	XX/XX									IN # 0000000	ر (۸۸۸	, ^^ - ^^		P# 0000	000



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES **CLAIMS SECTION** PO BOX 44269 **OLYMPIA WA 98504-4269**

Sample: Pathology

PLEASE PRINT OR TYPE 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) (ID) 000-00-0000 (SSN) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX Doe, Jane MM DD YY 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) 151 Oak Creek Lane Self Spouse Child Other 8. PATIENT STATUS CITY STATE WA Morton Married Other ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) Employed Full-Time Part-Time Student (360) 000-0000) 98519 (9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER Y 000000 (L&I Claim #) a. EMPLOYMENT? (CURRENT OR PREVIOUS) a. OTHER INSURED'S POLICY OR GROUP NUMBER a. INSURED'S DATE OF BIRTH YES NO MM DD ΥY b. AUTO ACCIDENT? PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME b. OTHER INSURED'S DATE OF BIRTH SEX YES NO DD XYZ Company C. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME ☐ YES ☐ NO d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE - I 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE - I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who authorize payment of medical benefits to the undersigned physician accepts assignment below. or supplier for services described below. SIGNED SIGNED 14. DATE OF CURRENT: 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION ILLNESS (First symptom) OR 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. INJURY (Accident) OR MM DD YY GIVE FIRST DATE MM DD DD DD TΩ PREGNANCY (LMP) 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES TO CURRENT SERVICES MM DD ΥY DD Xxxxxx Xxxxxx MD 0000000 FROM TO 20. OUTSIDE LAB? 19. RESERVED FOR LOCAL USE \$ CHARGES YES YES Ш NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) -----22. MEDICAID RESUBMISSION ORIGINAL REF. NO. 1. XXX.XX 23. PRIOR AUTHORIZATION NUMBER 2. |__ С G PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) DATE(S) OF SERVICE Type Of DIAGNOSIS RESERVED FOR CPT/HCPCS MM DD YY MM DD YY \$ CHARGES CODE LOCAL USE XXX.XX 03 | 01|01 03 | 01|01 XX 3 XX | XX 1 XXXXX 03 | 01|01 03 | 01|01 XXX.XX XX | XX XXXXX 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 25. FEDERAL TAX I.D. NUMBER 30. BALANCE DUE SSN FIN 28. TOTAL CHARGE 29 AMOUNT PAID ☐ YES☐ NO $\square X$ 00-0000000 Optional $XX \mid XX$ 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE 31 PHYSICIAN/SUPPLIER SIGNATURE INCLUDING DEGREES OR CREDENTIALS — (I certify that I understand L&I billing instructions, that information contained on this bill is consistent with those instructions and accurate to the best of my knowledge.) WERE PROVIDED (If other than home or office) AND PHONE # Pathology NW Inc 3112 Xxxxxx Lane Morton, WA 98519 PIN # 0000000 (XXX) XXX-XXXX | GRP# 0000000 SIGNED XXXXXXXX

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88)

f245-127-000 (3/92)



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION
PO BOX 44269
OLYMPIA WA 98504-4269

OLYMPIA WA 98504-4269
PLEASE PRINT OR TYPE Sample: Physical Therapy

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1.	PICA									L&I	1a. INSURED'S I.	D. NUMB	ER (F	OR PRO	OGRAM IN	ITEM 1)
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5. PATIENT'S A	(- ,	,				6. PATIEN			_		7. INSURED'S A	DDRESS	No., Stree	et)		
151 Oak	k Creek	Lane				Self S	pouse	Child	'	Other						
CITY					STATE 8	8. PATIEN	T STATUS	3			CITY					STATE
Morton					WA I	Cinala	Marr		,	Other						
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L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

Sample Physician PLEASE PRI NT OR TYPE

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L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

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2. PATIENT'S N	NAME (Last Na	me, First Name,	Middle In	itial)	3.	PATIENT'S	BIRTH	DATE		SEX	4. INSURED'S NA				e, Middle	Initial)
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L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

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1.	PICA									L&I	1a. INSURED'S I	.D. NUME	BER (F	OR PRO	OGRAM II	N ITEM 1)
										(ID)	000-00-0	0000	(SSN	1)		,
2. PATIENT'S N	IAME (Last Nar	ne, First Name,	Middle Ini	itial)	3.	PATIENT	'S BIRTH	DATE		SEX	4. INSURED'S N				e, Middle	Initial)
Doe, Jai	ne					MM E	DD YY		_	1 57						
·								М] _F 🗓						
5. PATIENT'S A	, ,	,			-	_	RELATIO	_	_		7. INSURED'S A	DDRESS	(No., Stre	et)		
151 Oak	Creek	Lane			Se	elfS	oouse	Child	\square	Other						
CITY					STATE 8.	PATIENT	STATUS	3			CITY					STATE
Morton					WA 🛭 si		Mar		ı	Other						
ZIP CODE	TE	LEPHONE (Inc	lude Area			ngle	iviari		l	Otner	ZIP CODE	TE	LEPHONE	(Includ	e Area Co	ode)
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9. OTHER INSU					Initial) 10). IS PATI				dent LJ ELATED TO:	11. INSURED'S F	POLICY G	ROUP OF	R FECA	NUMBER	
		,	,								Y 00000	0 (1 8	d Cla	im #	<u>!</u>)	
a. OTHER	R INSURED'S F	POLICY OR GR	OUP NUN	ИВЕR		EMPLOY	_ `			R PREVIOUS)	a. INSURED'S D			,,	/	SEX
						L	J YES	NO			MM DD	YY			М	
b. OTHER	R INSURED'S [DATE OF BIRTH	1	S	EX b.	AUTO A	CCIDENT		PL	ACE (State)	b. EMPLOYER'S	NAME O	R SCHOO	L NAME		<u> </u>
MM D	DD YY				F \square	L	YES	NO			XYZ Cor	nnan	V			
c. EMPLO	OYER'S NAME	OR SCHOOL N	AME		F C.	OTHER	ACCIDEN				c. INSURANCE F	PLAN NAN	ME OR PR	OGRAN	1 NAME	
						L	YES	NO								
d INSUR	ANCE PLAN N	NAME OR PROC	RAM NA	MF	10	d RESE	RVED FO	RIOCA	LUS	F	d. IS THERE AND	OTHER H	FAI TH BE	ENEEIT	PI AN?	
u					"	, a			_ 00	_						ete item 9 a-d.
12. PATIENT'S	OR AUTHORIZ	'ED PERSON'S	SIGNATI	IRF -	Lauthorize th	e release	of any m	edical or	othe	r information	13. INSURED'S (OR AUTH	ORIZED F	PERSON	'S SIGNA	TURF – I
necessary to	process this c	laim. I also requ									authorize paymer	nt of medi	cal benefit	s to the		
accepts assi	ignment below.										or supplier for ser	rvices des	cribed bel	ow.		
SIGNED					_ DATE .						SIGNED					
14. DATE OF CI MM DD		ILLNESS (Fir INJURY (Acc				PATIENT H /E FIRST		AME OR S MM	IMILA DE	R ILLNESS. YY	16. DATES PATI			VORK IN		NT OCCUPATION DD YY
	_	PREGNANC'	Y (LMP)								FROM			TO	- 1	
17. NAME OF R			THER SC	DURC	l l			EFERRIN	NG P	HYSICIAN	18. HOSPITALIZ			CURRE		CES DD YY
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0.1					•						23. PRIOR AUTH	IORIZATI	ON NUME	BER		
2.	·			4.	<u> </u>											
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DATE(S) C	OF SERVICE	PLACE OF	Type Of	Р	ROCEDURES				S			Days Or	EPSDT Family	FMG	СОВ	
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billing instructions, that in with those instructions as	nformation contained o	n this bill is consistent	ai .	** L/L	. I NOVIDED	(11 OUTET U	ian nome	or onice	,		Xxxxxx Xxxxxx, D	PM				
war arose instructions at	accurate to the Desi	. o. my knowledge.)									3112 Xxxxxx Lane Morton, WA 9851		() XXX-XX	'YY		
SIGNED XXXX	XXXXX	DATE XX/XX/X	,, l								PIN # 0000000		·, ^^^-^^		P# 0000	000



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269

OLYMPIA WA 98504-4269
Sample: Psychologist PLEASE PRINT OR TYPE

	PICA		,	FLLAS	LFKII	VI OI	\ IIIL			_	- ,		9.00				Р	ICA T
1.	TIOA									_	L&I		1a. INSURED'S I				OGRAM II	N ITEM 1)
											(ID)		000-00-0	000	(SSN	1)		
2. PATIENT'S N	•	ame, Firs	st Name,	Middle Ir	nitial)		3. PATI	ENT'S BIRTH	DATE		SEX		4. INSURED'S NA	AME (La	st Name, F	irst Nam	ne, Middle	Initial)
Doe, Ja	ne						MM	DD YY	М	Г] _F 🔀							
5. PATIENT'S A	ADDRESS (No	., Street)				6. PATI	ENT RELATIC					7. INSURED'S AL	DDRESS	(No., Stre	et)		
151 Oal	k Creek	Lar	ne				Self	Spouse	Child		Other							
CITY					1 0-	TATE	0.047	· ·		_			CITY					OTATE
Morton						TATE VA		ENT STATUS					CITY					STATE
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							l	YES	NO				MM DD	YY			М	□ _F □
	R INSURED'S	DATE C	OF BIRTH	Н	SEX		b. AUTO	O ACCIDENT? YES	NO	PL	ACE (State)	f	b. EMPLOYER'S	NAME C	R SCHOO	DL NAME		<u> </u>
MM [DD YY			M			l				II		XYZ Cor	npar	Ŋ			
c. EMPL	OYER'S NAME	E OR SC	CHOOL N	NAME			C. OTH	ER ACCIDENTY YES	NO NO			f	c. INSURANCE P			ROGRAN	/ NAME	
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d. INSUF	RANCE PLAN	NAME (OR PRO	GRAM N	AME		10d. RE	SERVED FOR	R LOCAL	_US	E		d. IS THERE AND					ata itam 0 a d
													YES	_	•			ete item 9 a-d.
12. PATIENT'S	OR AUTHORI o process this												 13. INSURED'S C authorize paymer 					
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17. NAME OF F				THER S	OURCE			JMBER OF RE	FERRIN	IG P	HYSICIAN		18. HOSPITALIZA MM			CURREI		ICES DD YY
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billing instructions, that with those instructions a													Xxxxxx Xxxxxx, Pl 3112 Xxxxxx Lane					
													Morton, WA 9851		X) XXX-XX			
SIGNED XXX	XXXXX	DATE	XX/XX/	~~									PIN # 0000000			GR	P# 0000	000



L&I HEALTH INSURANCE CLAIM FORM

DEPARTMENT OF LABOR AND INDUSTRIES CLAIMS SECTION PO BOX 44269 OLYMPIA WA 98504-4269

PLEASE PRINT OR TYPE Sample: Radiology

	PICA															OICA I
1.	FICA									L&I	1a. INSURED'S I	.D. NUMI	BER (F	OR PRO	OGRAM I	N ITEM 1)
								[(ID)	000-00-0	0000	(SSN	1)		
2. PATIENT'S N	NAME (Last N	Name, First Na	me, Mido	dle Init	ial)	3. PA	TIENT'S BIRTH D	DATE	S	EX	4. INSURED'S N				e, Middle	Initial)
Doe, Ja	ne					MN	M DD YY	Г	\neg	$_{F}\mathbf{X}$						
5. PATIENT'S A	ADDRESS (N	lo Street)				6 PA	TIENT RELATION				7. INSURED'S AI	ODRESS	(No Stre	et)		
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98519		(360) (oyed Full-Till Studer				11. INSURED'S F	'	,			
9. OTHER INSU	JKED'S NAM	ie (Last Name	, FIRST IN	ame, iv	iladie initia	<i>'</i>	PATIENT'S CON				Y 00000					(
2 OTHE	D INGLIDED	S POLICY OF	CPOLIE	MIIIA	BED	a. EM	PLOYMENT? (CI	JRRENT	OR	PREVIOUS)	a. INSURED'S D	`		H 1111	·)	SEX
a. OTTIL	IN INSURED	3 FOLIOT OI	GINOUF	INCIVI	DLIX		YES	NO			MM DD	YY	DIIXIII			
h OTHE	R INSURED	S DATE OF E	IRTH		SEX	b. AU	TO ACCIDENT?		PLA	CE (State)	b. EMPLOYER'S	NAME C	R SCHOO	NAME	M	L F L
	DD YY	0 5/112 01 2				7	YES	NO	I_		XYZ Cor)	-	
. c. EMPLO	OYER'S NAM	ME OR SCHO	OL NAME	M	<u> — ғ</u> с	С. ОТ	HER ACCIDENT				c. INSURANCE P			ROGRAN	I NAME	
							YES] NO								
d. INSUR	RANCE PLAN	NAME OR I	ROGRA	M NAI	ME	10d. F	RESERVED FOR	LOCAL U	JSE		d. IS THERE AND	OTHER H	IEALTH B	ENEFIT	PLAN?	
											YES	NO	If yes, re	eturn to a	and comp	lete item 9 a-d.
12. PATIENT'S	OR AUTHO	RIZED PERSO	N'S SIG	NATU	RE – I autl	horize the re	lease of any med	lical or oth	her ir	nformation	13. INSURED'S (OR AUTH	ORIZED F	PERSON	i'S SIGN/	ATURE – I
	o process thi		request p	oayme	nt of gover	nment bene	fits either to myse	elf or to the	e pa	irty who	authorize paymer or supplier for ser				undersigr	ned physician
accepts ass	signinent beic	vv.									or supplier for ser	vices de	scribed be	Ow.		
SIGNED						DATE					SIGNED					
14. DATE OF C	URRENT:	, ILLNES	S (First s)	/mptor	m) OR		ENT HAS HAD SAM	E OR SIMIL	IARI	ILLNESS		ENT UNA	BLE TO V	VORK IN	CURRE	NT OCCUPATION
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17. NAME OF F	<u> </u> REFERRING	PREGN PHYSICIAN (URCE	17a. I.D. N	NUMBER OF REF	ERRING	PH	<u> </u> YSICIAN	FROM 18. HOSPITALIZA	I ATION D	ATES TO	TO CURREI	NT SERV	ICES
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											│ □ _{YES} □] _{NO}				1
21. DIAGNOSIS	S OR NATUR	E OF ILLNES	S OR IN	JURY.	(RELATE	ITEMS 1, 2,	3 OR 4 TO ITEM	1 24E BY	LINE	=) 1	22. MEDICAID R		SSION			-1
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00-0000 31. PHYSICIAN/S	0000 SUPPLIER SIGN	NATURE INCLUI	ING	3	Option 2. NAME A	nal	ESS OF FACILITY	WHERE	ΥE	s No	\$ XX	XX , SUPPL	\$		I	
00-0000 31. PHYSICIAN/S DEGREES OR CR billing instructions, that	0000 SUPPLIER SIGN REDENTIALS — Information contain	NATURE INCLUI	ING stand L&I stent	3	Option 2. NAME A	nal		WHERE	ΥE	s No	\$ XX 33. PHYSICIAN'S AND PHONE Jones Radiology I	XX , SUPPL #	\$		I	\$
00-0000 31. PHYSICIAN/S DEGREES OR CR	0000 SUPPLIER SIGN REDENTIALS — Information contain	NATURE INCLUI	ING stand L&I stent	3	Option 2. NAME A	nal	ESS OF FACILITY	WHERE	ΥE	s No	\$ XX 33. PHYSICIAN'S AND PHONE	XX , SUPPL # inc	\$	ING NA	I	\$

REBILLS

REBILLS should be submitted when:

Your TOTAL BILL has been denied.

Your bill was sent in over 60 days ago and is not yet showing up on your Remittance Advice

You are **required** to REBILL: (WAC 296-20-125)

- For TOTAL BILLS denied because the claim was closed and the claim has now been reopened
- For TOTAL BILLS denied because the claim was first rejected and the claim has now been allowed.
- For TOTAL BILLS denied because a diagnosis was at first not allowed and the diagnosis has now been allowed

Rebills must be <u>received</u> at the department within one year of the date the final order was issued which reopened or allowed the claim or diagnosis.

A Rebill should be identical to the original bill: same charges, codes and dates of service. Rebills should be submitted on new **ORIGINAL** bill forms. We cannot process photocopies or facsimiles.

ADJUSTMENTS

A "Providers Request for Adjustment " form (F245-183-000) should be submitted to correct an incorrect field on a bill that has already processed and partially paid.

Enter the workers name (field 1), their claim number as it appears on your REMITTANCE ADVICE (field 2), the correct claim number if applicable (field 3), the providers name and address (field 4), the ICN (internal control number) of the bill (field 5) as it appears on your REMITTANCE ADVICE (see example headings below for location of the ICN as it appears on your REMITTANCE ADVICE), the performing providers L&I provider number (field 6) and L&I payee number (field 7), if applicable.

			Service	Dates			Billed
me I	Patient Acct#	ICN	From	To	Unit	Procedure	Charge
		<u></u>					_
XXXXX X	XXXXXXXXX	00101825045000200	121300	12/17/01	1 1	XXXXX	XX.XX
•		1 1 000000	xxxxx x xxxxxxxxxx 00101825045000200	me I Patient Acct# ICN From		ame I Patient Acct# ICN From To Unit	me I Patient Acct# ICN From To Unit Procedure

In the body of the form (field 8) correct only those line item fields that have been paid or denied incorrectly due to incorrect information. Enter only the corrected information (as it should have appeared on the original bill) in the line item fields corresponding to the line item fields on your bill as it appears on your REMITTANCE ADVICE.

EXAMPLE:

You billed one unit of service on line one but four units were actually completed and should be payable. You've only been paid for one unit. Everything else on the bill is correct. In field 8, on line one of the adjustment form, enter '4' in the 'unit' field. After the adjustment processes you will receive payment for the three units previously unpaid.

Please attach to the adjustment form a copy of your ORIGINAL BILL and a copy of the page of your REMITTANCE ADVICE where your paid bill appears.

Request for Reconsideration on adjustments initiated by the department

Per legal notice on your REMITTANCE ADVICE, a request for reconsideration of a payment must be made in <u>writing</u> within 20 days of receipt of notice of the adjustment/deduction.

The basis for the request for reconsideration must be other than an objection to the payment amount established by the departments' fee schedule.

All supporting documentation relevant to the reconsideration request must be submitted with the request.

Note:

DO NOT SUBMIT an adjustment or a rebill for a bill that is reported "in process" on your Remittance Advice. If the bill remains in the "in process" status for **over 60 days**, call our Provider Hotline at 1-800-848-0811. For bills "in process" **under 60 days** you may access the Claim Information Line by calling 1-800-831-5227. Once you access the 'in process' bill information, you may choose the 'zero' option to be connected to the bill payment section.

Adjustments will appear as the last item on the Remittance Advice as follows:

(See sample RA on page 37)

Your original bill will be reprinted, appearing as a credit for the amount previously paid, (e.g., \$100.00 - CRE).

Your adjustment will usually appear immediately following the credit of your bill.

If an additional payment is allowed, the total amount allowed for the bill will be reported (e.g., \$125.00). The difference between original and adjusted payment will be paid in the warrant (e.g., \$25.00).

If no additional fee is allowable, the amount of the adjustment will be equal to the credit of the previous payment (e.g., \$100.00).

If the original payment is being recouped, the total or partial amount allowed for the bill will be reported (e.g., \$0.00). The "adjusted payment" will recoup the original amount of the bill and report the difference as a credit (monies owed back to the department).

NO STAPLES IN BAR CODE AREA



Department of Labor and Industries Claims Section PO Box 44267 Olympia WA 98504-4267

PROVIDER'S REQUEST FOR ADJUSTMENT

CHECK ONE \rightarrow

TOTAL OVERPAYMENT PARTIAL OVERPAYMENT UNDERPAYMENT

DO NOT		
WRITE	I	Ν

SPACE	Please type or print in	Dark ink
ENTER DATA FROM ORIGINAL REMMITTANCE ADVICE	INSTRUCTIONS A	RE ENCLOSED
 WORKERS NAME (Last, First, Middle) 	2) CLAIM NUMBER ON REMIT ADVICE	3) CORRECT CLAIM NUMBER
4) PROVIDER NAME AND ADDRESS	5) ICN NUMBER ON REMITTANCE ADVICE	
	6) PROVIDER NUMBER	
	7) PAYEE NUMBER	

5)			b)	c)		e)	NFORMATION f) ICD-9-CM	g)	h)	i) Days/	j)	k)
ine	a)	From/to Date of	P	T	d) Procedure Code/	CODE	Diagnosis/	Tooth	Charge	Units/	Days	Description
em	,	Service pr overed	o	ò	Revenue Code/NDC	MOD	Side of Body	No.	Cinargo	Quantity	Supply	Description
0.		Dates	S	S						Ç	~ - FF-7	
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,1												
)2	1											
12												
)3												
,5												
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4	1							1	1	+	1	1

^{9.} OTHER REMARKS/JUSTIFICATIONS/SPECIAL CIRCUMSTANCES - ATTACH REQUIRED REPORTS - EXPLAIN FULLY

DATE	SIGNATURE OF PERSON COMPLETING FORM	PHONE NUMBER				
		()				

ADJUSTMENT REQUEST FORM

THE ADJUSTMENT REQUEST FORM MAY BE USED IN THE FOLLOWING INSTANCES:

TOTAL OVERPAYMENT ----

Entire bill was paid in error. You may either submit an Adjustment Request Form and we will process a credit to recover our payment; OR you may issue a refund check directly to the Department. If a refund is submitted, you must attach a copy of the remittance advice indicating

the ICN overpaid. Submit refunds to:

Cashiers Office Department of Labor and Industries PO Box 44835 Olympia WA 98504-4835

PARTIAL OVERPAYMENT ---A portion of the bill was overpaid. Complete Adjustment Request Form with correct information,

including date of service, for the procedures/items paid incorrectly.

UNDERPAYMENT -----If a bill has been underpaid in error, the Adjustment Request Form must be completed with all

pertinent information including date of service. Corrections or justification and/or reports must be

included.

This form may **NOT** be used for:

Bills returned to you by the Department **OR** totally denied bill. New bill must be submitted.

INSTRUCTIONS FOR COMPLETING ADJUSTMENT REQUEST

Submit only one form for each ICN (Internal Control Number). Attach a copy of remittance advice and original bill.

- 1. WORKER'S NAME: Clearly print injured worker's full name.
- 2. CLAIM NUMBER ON REMITTANCE ADVICE: Enter the 7-digit number found in the Claim Number column on the remittance advice.
- 3. CORRECT CLAIM NUMBER: Claim number these services should be paid under.
- 4. PROVIDER NAME AND ADDRESS: Enter the name and address of the provider providing the service. Include telephone number.
- 5. ICN NUMBER: Enter the 17-digit number found in the ICN column to identify the bill submitted.
- **6. PROVIDER NUMBER:** Enter the Labor and Industries provider account number for the provider of service as it appears on the remittance advice.
- 7. PAYEE NUMBER: Enter the Labor and Industries payee provider account number if payee was different than the provider
- **SERVICE ITEMIZATION:** Complete only for those line items to be corrected. Enter corrected information on line item number corresponding to line item number on original bill.
 - a. From/to Date of Service or Covered Dates: Date of Service, from and to date if date span previously billed. Admit and discharge date for hospital bill.
 - b. Place of Service: (POS) Two digit code identifying the place of service was performed.
 - **c. Type of Service:** (TOS) One digit code identifying the general type of service performed.
 - d. Procedure Code/Revenue Code/NDC: Identify correct procedure, hospital service or national drug code.
 - e. Code Mod: Modifier used to identify special circumstances for a service or procedure.
 - ICD-9-CM Diagnosis/Side of Body: ICD-9-CM diagnosis code for condition treated. Designate left or right side of body where applicable.
 - **Tooth Number:** For dental services only. Enter the two digit identification number of the specific tooth number treated (e.g., 08).
 - h. Charge: Total of charges for services provided this line.
 - i. Days/Units/Quantity: Total days stay for hospital accommodation codes, unit of service for procedure (time units, hours, miles, etc.), number of items (tablets, milliliters, etc.).
 - **Days Supply:** Total number of days a prescription is intended to cover.
 - **k. Description:** Describe procedure or service.
- 9. OTHER REMARKS/JUSTIFICATION/SPECIAL CIRCUMSTANCES: Enter sufficient justification for adjustment. Indicate the service line and date of service. Attach required reports.

SAMPLE PAGE BLMC8000-R001 AS OF 04/27/2002

DEPARTMENT OF LABOR AND INDUSTRIES OLYMPIA, WASH 98504

007589

REMITTANCE ADVICE

INSTRUCTIONS:

1. REFER TO LAST PAGE FOR LEGAL NOTICES

- 3. FOR HELP WITH FINALIZED BILLS: CALL 1-800-848-0811
- 2. FOR HELP WITH SUSPENDED BILLS: CALL 1-800-831-5227

PAYEE PR	OVIDER NUM	1BER	0000000 REMIT	ADVICE # XXXXXX W	ARRANT RE	GISTER NU	MBER	60048 DATE	04/30/2002	PAGE X			
CLAIM NUMBER	NAME	I	PATIENT ACCT/RX NUMBER	ICN	SERVICE FROM	DATES TO	UNIT OF SVC	PROCEDURE REVENUE NDC	BILLED CHARGES	ALLOWED	TAX OR NON- COVD CHARGES	PAYABLE	EOB CODES
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	ADJUSTMENT TOTALS – PRACTITIONER BILL					OTAL*** R OF BILLS	-	2	XXX.XX XXX.XX	XXX.XX XXX.XX	0.00 0.00	XXX.XX XXX.XX	

EOB 045 - Denied. Type Service/Procedure Code is invalid. Refer to current Fee Schedule for valid code.

TYPE OF SERVICE CODES:

C Chiropractic Services
 D Drugless Therapeutics
 I Inpatient
 P Physical Therapy
 V Vocational Services
 Medical Services

N Nurse Practitioner Services 4 Dental

O Outpatient 9 AncillaryServices (attendant, equipment, glasses)

PLACE OF SERVICE CODES:

- 03. School
- 04. Homeless Shelter
- 05. Indian Health Service Free-standing Facility
- 06. Indian Health Service Provider-based Facility
- 07. Tribal 638 Free-standing Facility
- 08. Tribal 638 Provider-based Facility
- 11. Office
- 12. Patient's Home
- 15. Mobile Unit
- 21. Inpatient Hospital
- 22. Outpatient Hospital
- 23. Emergency Rm Hospital
- 24. Ambulatory Surgical Ctr
- 25. Birthing Ctr
- 26. Military Trmt Facility
- 31. Skilled Nursing Facility
- 32. Nursing Facility
- 33. Custodial Care Facility
- 34. Hospice
- 41. Ambulance Land
- 42. Ambulance Air or Water
- 50. Federally Qualified Hlth Ctr
- 51. Inpatient Psychiatric Facility
- 52. Psychiatric Facility Partial Hospitalization
- 53. Community Mental Health Ctr
- 54. Intermediate Care Facility/Mentally Retarded
- 55. Residential Substance Abuse Trtmt Facility
- 56. Psychiatric Residential Trmt Ctr
- 60. Mass Immunization Ctr
- 61. Comprehensive Inpatient Rehabilitation Facility
- 62. Comprehensive Outpatient Rehab Facility
- 65. End Stage Renal Disease Trmt Facility
- 71. State or Local Public Health Clinic
- 72. Rural Hlth Clinic
- 81. Independent Laboratory
- 99. Other Unlisted Facility

Directory:

Field Service Offices

415 West Wishkah, Suite 1B Aberdeen:

Aberdeen WA 98520-0013

(360) 533-8200

(509) 826-7345

1234 2nd Avenue S

616 120th Avenue NE, Suite C201 Bellevue:

Bellevue WA 98005-3037

(425) 990-1400

Port Angeles: 1605 East Front Street, Suite C

Port Angeles WA 98362-4628

Okanogan WA 98840-0632

(360) 417-2700

1720 Ellis Street, Suite 200 Bellingham:

Bellingham WA 98225-4600

(360) 647-7300

Pullman: 1250 Bishop Blvd SE, Suite G

PO Box 847

Pullman WA 99163-0847

(509) 334-5296 1-800-509-0025

Bremerton: 500 Pacific Avenue, Suite 400

Bremerton WA 98337-1904

(360) 415-4000

Seattle: 300 W Harrison Street

Seattle WA 98119-4081

(206) 281-5400

Colville: 298 South Main, Suite 203

Colville WA 99114-2416

(509) 684-7417 1-800-509-9174 Spokane: 901 N Monroe Street, Suite 100

Spokane WA 99201-2149

(509) 324-2600 1-800-509-8847

East Wenatchee: 519 Grant Road

East Wenatchee WA 98802-5459

(509) 886-6500 1-800-292-5920 Tacoma: 950 Broadway Suite 200 NEW Tacoma WA 98402-4453

ADDRESS (253) 596-3800

729 100th St SE Everett:

Everett WA 98208-3727

(425) 290-1300

Tukwila: 12806 Gateway Drive

PO Box 69050

NEW PH# Seattle WA 98168-1050

Okanogan:

(206) 835-1000

Goldendale: 777 E Broadway, Suite E

Goldendale WA 98620-9286

(509) 773-3723

Tumwater: PO Box 44851

> 7273 Linderson Way SW Olympia WA 98501-5414

(360) 902-5799

4310 W 24th Ave Kennewick:

Kennewick WA 99338

NEW (509) 735-0100 **ADDRES** 1-800-547-9411 Vancouver: 312 SE Stonemill Dr. Suite 120

Vancouver WA 98684-3508

(360) 896-2300

Longview: 900 Ocean Beach Hwy

Longview WA 98632-4013

(360) 575-6900

Walla Walla: 1815 Portland Avenue, Suite 2

Walla Walla WA 99362-2246

(509) 527-4437

Moses Lake: 3001 W Broadway Ave

Moses Lake WA 98837-2907

(509) 764-6900

Yakima: 15 W Yakima Avenue, Suite 100

Yakima WA 98902-3401

(509) 454-3700 1-800-354-5423

Mount Vernon: 525 E College Way, Suite H

Mount Vernon WA 98273-5500

(360) 416-3000

• indicates Regional Office

(Revised 5/7/2002)